

**Death and the pub: A discourse analysis of men's talk
about mental health, mental illness and mental health
services**

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INTRODUCTION TO THE PORTFOLIO

This portfolio contains a selection of work completed during the Doctorate of Psychology (PsychD) clinical training course.

The portfolio is comprised of three sections: the Academic Section, containing two Essays, two Problem-Based Learning Accounts, and two Personal and Professional Learning and Discussion Group Process Account Summaries; the Clinical Section, containing an Overview of Clinical Experience over the Five Placements, and five Case Report Summaries; and the Research Section, comprising the Service Related Research Project, an Abstract of the Qualitative Research Project, the Major Research Project, and the Research Log Checklist.

The work presented reflects the range of client groups, presenting problems and psychological approaches covered during the course.

All work has been anonymised in order to maintain confidentiality.

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ACADEMIC SECTION

Literature Review

**Mental health and religion in the adult population: taking a
positive relationship between mental health and religiosity
seriously in clinical psychology**

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ABSTRACT

Despite the prediction that religion would wane in the 21st century, evidence suggests otherwise. It is important therefore for mental health professionals to understand the role of religion in the lives of their clients and to appreciate its impact on mental health. Research suggests a moderate inverse relationship between religion and depression and anxiety with some cross-cultural support. The relationship is however complex and context needs to be taken into account. The effect of culture and the importance of intrinsic religiosity are discussed. Much research is conducted in the US in the field of psychiatry, suggesting a gap in the British psychological literature. Some implications for clinical practice are discussed. The interplay between religion, culture and wellbeing is discussed.

Keywords

Religion, religiosity, spirituality, mental health, depression, anxiety

INTRODUCTION

This review focuses on the reported positive relationship between religion and mental health. Dein (2004) claims that historically both psychiatrists and psychologists have underestimated the importance of religion in their work (e.g. Sims, 1994). Within psychology, interest in religion waned somewhat after initially blossoming with the work of Freud, Allport, Ellis, Kohut, Jung and others (Dein & Loewenthal, 1998). Some interest in religion and spirituality was carried forward by the post-Freudians (Heimbrock, 1991). There is a renewed interest however within psychology in between and within group differences in religiosity and mental health, in plurality of belief, and in the religious underpinnings of the individual psychologist's position (O'Connor, 2002).

Definitions

Culture can be understood as a shared system of beliefs, customs and behaviours (During, 1995), one of which is religion. Defining and operationalising complex phenomena such as religion, religiosity, religiousness, spirituality and mental health is problematic because of the multiplicities of understandings of the phenomena (Worthington *et al.*, 1996). For the purposes of this review, religion will be defined as a devotion to and the beliefs and practices of an organised church (Shafranske & Maloney, 1990). Religiosity/ religiousness will be defined as having belief structure, a moral framework, an authority structure and an accepted form of worship (Hayes & Cowie, 2005). A person's religiosity can vary greatly; highly religious

people are considered those in the top 10% to 15% on measures of commitment to their particular faith, or how salient their faith is in their lives (Worthington *et al.*, 1996). Religious beliefs are holding true, statements in relation to a particular religion (Worthington *et al.*, 1996: 449). Spirituality is defined as holding sacred 'the deep connections' between living things and a "higher being" ' (Reich, 2000). One definition of mental health is a competent expression of feelings, responsibility and autonomy, self-awareness and growth, interpersonal competency, a mature attitude and a capacity for forgiveness (Masters & Bergin, 1992).

One of the methodological failings in the literature is the lack of consistency in defining and operationalising terms across studies (Dein, 1996). Religion is also an aspect of culture, and therefore is defined within a particular context. Since most of the research into religion in psychology is framed within a Judeo-Christian context, when this review refers to religiosity and religion, implicit is a reference to a personal God (Pieper & van Uden, 1996).

My Position

As an atheist Jewish mental health practitioner, I became concerned that I did not take religion sufficiently seriously. For example, in my own clinical practice, I worked with a Jewish adolescent diagnosed with bipolar disorder, who experienced religious delusions. He refused to co-operate with other staff and claimed that because I 'shared' and could understand his orthodox convictions, he would only work with me. He did not know that I am an atheist, or that I do not practice any of the Jewish rituals I was taught as a child. He

assumed only that I was sensitive to his beliefs and practices and reacted very positively to my Jewish surname and the little Hebrew I knew. Initially I suspected that his Judaism might have contributed towards his ill health. I suspected a causal link because his delusions contained many religious Jewish references and because in his home environment, it appeared that Orthodoxy took on a punitive and totalising character. However I came to realise that it was partly his faith, and partly his faith in my faith that allowed him to become well again. This may have been attributable to the social connection that a shared religion allowed us. What mattered was that to fully understand his experience I, as a clinical practitioner, needed to appreciate the relative interplay between his faith and his mental health. I am interested then in the relationship between mental health and religiosity. I am cognisant also of my tendency to underestimate, even dismiss, the role of religion in people's lives.

Method

Initially I cast widely for on-line journal articles using academic search engines relating mental health and religion, using the key words of religion, religiosity, mental health, and depression. This led to a vast amount of psychiatric literature, but uncovered a gap in empirical studies in the UK psychological literature. The psychiatric literature was very broad and thus I narrowed the search to research covering the last 20 years, which supported the positive impact of religion on managing depression and anxiety. Not all studies could

be discussed in similar detail. Rather, salient studies in each area are discussed.

Religious breakdown in the UK

Contrary to the perception that UK society is becoming more secular and atheistic, in the UK nearly 80% of white British adults, with a similar percentage for Afro-Caribbeans, defined themselves as Christian in the latest Census (2001, Office of National Statistics), some 36 million people. Only 12% and 10% respectively claimed to have no religion at all. Of Pakistanis and Bangladeshis, over 90% defined themselves as Muslim, and none claimed any religion. Of Black Africans, just under 70% defined themselves as Christian, and less than 10% as not having a religion. Amongst whites, there are also over a quarter of a million Jews and a considerable proportion of Buddhists. Of Indians, less than 5% claimed no religion. It seems that more than 85% of UK residents still define themselves as having a religion. Furthermore, the Census failed to measure the significant concomitant rise in spirituality and New Age religions (Carr, 2000).

RELIGION AND MENTAL HEALTH

Service-user perspective

In the 1997 Mental Health Foundation Study of adult service users experiencing serious mental distress (Lindgren & Coursey, 2000), two thirds felt that discussing their religious views in relation to their current distress with

mental health professionals was imperative to their mental health. Less than half were doing so. The study threw light on the centrality of religion in the lives of more than half of the 400 service users interviewed (Macmin & Foskett, 2004). It demonstrated the remarkable positive effect on service users' recovery when religiosity was considered. Better relationships between service users and health workers facilitated a greater understanding of the presenting problem, and when psychiatrists referenced clients' religious beliefs, it aided service users' perception of their own recovery. Clients were often alone in recognising the importance of religiosity as a search for meaning when distressed:

God has become my everything. I know that without my faith I would not have survived the child sexual abuse, the abusive relationships, the suicide attempts made by my son. p.33.

In a paper *Making Space: Spirituality and Mental Health*, Julie Leibrich, ex-New Zealand Commissioner for Mental Health and a sufferer of depression writes about the usefulness of spirituality in her own mental distress (2002, p.149):

Sometimes I have a kind of miraculous experience ... that involves spiritual insight. I know, deep within, that at these times, I am healing.

They are aware of the transformative impact of religion in alleviating distress and aiding recovery. Studies suggest that service users want their religious views to be taken as seriously by mental health professionals as their psychosocial states.

A POSITIVE RELATIONSHIP

There exists a substantial body of psychiatric literature supporting the positive effect of religion and spirituality on mental health within both clinical and community populations, particularly within the US (Dein & Loewenthal, 1998). Religiosity has been associated with the alleviation of the fear of death and dying (Hayes & Cowie, 2005). Religion as a stress buffer is well documented (e.g. Worthington *et al.*, 1996). It has been found to lower distress (McIntosh *et al.*, 1993) and provide social support (Shams & Jackson, 1993). Religious cognitions have been found to aid coping with distressing thoughts (Loewenthal & Macleod, 1998). There has also been significant documentation of the healing effects of spirituality and religion in recovery (Dein & Loewenthal, 1996), as well as the use of prayer as a coping method (e.g. Loue & Sajatovic, 2008).

DEPRESSION

Overview

Overall, greater religiosity has been linked to improved measures on depression (Koenig, 2001). Greater private religious activity and particular religious beliefs (e.g. belief in God, belief in life after death) have also been associated with lower incidences of depression (Koenig *et al.*, 2001 in Rosmarin, Pargament & Maloney, 2009: 98).

Religiosity and church attendance

In a recent study, Mansfield *et al.* (2008) found that weekly worship attendance was associated with lower depression scores (measured using the BDI-II) in a mainly male and largely aboriginal inpatient forensic sample (n=181) in Canada. This study investigated the link between religiosity, depression, and anxiety. It concluded that the percentage of people who engaged in regular church attendance was higher than the general population (38.5% compared to about 22%), perhaps suggesting that incarceration had led many to search for meaning through religious attendance. Higher religiosity and spirituality scores were associated with lower depression and anxiety scores and higher satisfaction with life scores. Interventions from spiritual advisors, partaking in rituals, and social support could account for the higher level of psychological wellbeing found in the sample. The positive effect could be due to increased belonging or to a greater sense of purpose provided by religious participation. However this is difficult to unpick as the measures used were not formally normed on an aboriginal sample and were designed by forensic psychiatrists. Furthermore, the aboriginal population was a heterogeneous mix of Cree, Metis and French, displaying a variety of religious beliefs. Also, self-report measures should be independently correlated with religious leaders' reports on worship attendance, positively affecting the validity of claims of religiosity.

Religious practice

Both quasi and experimental studies of spiritual and religious activities support the positive effect on depression demonstrated in samples drawn from clinical populations (Koenig *et al.*, 2001). For example, in the first such study, also in an acute Canadian setting (n=88), religious clients recovered faster from depression and had a shorter stay in two tertiary hospitals (Baetz *et al.*, 2002). The study found better long-term clinical outcomes for those in-patients with higher religious commitments. Both measures used (the Duke Religion Index and the Religious Coping Index) were again designed by psychiatrists and rely at least in part on self-report. Future research should look at generalizing outside of limited Canadian settings. Baetz *et al.* (2002) argued that religious practices, such as prayer and frequent worship, accounted for a buffering effect against depressive symptoms, however they did not find that frequency improved depressive outcomes.

This finding is supported by research by McCullough and Larson (1999) who argue that private prayer has a tenuous effect on depression. Also, although Baetz *et al.* (2002) found a relationship between higher frequency of communal religious worship as well as private spirituality and lower depressive scores (rated using the BDI-II), a causal inference cannot be inferred. Furthermore, the cross-sectional nature of the religiosity measure does not accurately reflect lifetime religiosity. Since the sample is limited to a particular area, results may not be generalisable outside of the hospitable. Future studies need to measure, and so account for, the variety of co-morbid symptoms mediating depression scores.

Adapted cognitive behavioural therapy (CBT)

There is also some evidence to suggest that religious adaptations of CBT have positive effects on depression. One randomized control trial (RCT) (n=59), conducted by Propst *et al.* (1992), found that those clients offered religious based CBT (RBCBT) demonstrated a reduction in depression scores compared to the waiting list when tested on a pre-test post -test measure, as well as a 3 month and 6 month follow up (cited in Worthington *et al.*, 1996). Those receiving non-religious CBT or pastoral counseling therapy (PCT) demonstrated a slower reduction in depressive symptoms. Both CBT therapies consisted of 18 1- hour sessions, PCT consisted of discussion of religious themes. The religiosity of the therapists was crossed and in fact non-religious therapists outperformed all other trials. Propst *et al.* (1992) thus argued for cautious support for adapting CBT for religious clients. Although this finding has not been replicated, adapting CBT for Mormon clients with perfectionistic tendencies and depression has proved effective in another RCT (Richards *et al.*, 1993 in Worthington *et al.*, 1996). Similar RBCBT could be adapted for members of different religious groups to test whether effects are culture-bound.

Meta-analyses

Psychiatrists Koenig *et al.* (2001) looked at how religious factors were correlated with improved mental health in 1,200 outcome studies and 400 critical literature reviews of both clinical and community samples. They reported that religious belief was beneficial to mental health in more than 80%

of the studies (Sims, 2004, p.295). Interestingly, when the effect of religious participation was also taken into consideration, Koenig (2008) reported a consistent and replicable negative relationship between depression and religion in a meta- analysis of 20 years of research up to 2000. 63% of 93 studies showed a lower rate of depression or lower depressive symptoms among those with higher religious beliefs or more religious practices. Of the 93 studies however, only 22 were prospective, but those participants with higher religiosity at baseline were predictive of either lower rates of depression in future years, or quicker recovery. Only 15 studies showed that higher religiosity predicted lower depressive symptoms over time, 71 were cross –sectional. Five of the 8 RCT studies showed that those receiving religious interventions improved quicker than controls or those receiving secular interventions. This remains true despite social participation being a factor in all three groups. This result was replicated by a sample of 5,726 of churchgoers (Stack & Wasserman, 1992), amongst others.

A further meta analysis of 147 studies, conducted by Smith *et al.* (n=100,000), found only a weak -0.15 correlation between religiosity and distress (Koenig, 2008). Though apparently small, this relationship is equivalent to the effect of gender, and is thus statistically significant. The power may not reach clinical significance.

Most of these studies are however conducted in Judeo- Christian contexts. Future research should focus on cross-cultural RCT comparisons as to the relative impact of particular cultures and religions on mental health. This would allow researchers to better ascertain whether it is religion in general, or

rather the characteristics of particular religions, that has an impact on depressive symptoms.

Other clinical samples

The positive effect of religiosity has also been found in older samples. In a study of 850 older American men, Koenig and Cohen (2002) found an inverse relationship between religiosity and both objectively and subjectively reported depression. However a similar study conducted in Norway amongst cancer patients found that nearly half did not perceive religion as comforting. This suggests that religion may be culturally mediated as a factor in psychological coping, and that its use is a function of the religiosity and spirituality of the community. Hopelessness as a result of being diagnosed with a terminal illness, may also explain the patients' failure to gain comfort from religion. Again this study only addresses the beliefs and practices of a Christian population.

Jewish religiosity

Rosmarin, Pargament and Mahoney (2009) conducted one of the few studies of religiosity and mental health related specifically to Jews. Drawing on a large American, Canadian and Israeli community sample (n=565, 57.8% female, aged 17 to 77), they found that, while those who reported a higher trust in God (a particularly Jewish construct, they argue) had lower levels of anxiety and depression, overall Jewish religiousness was unrelated to mental

wellness. The authors argue that while global religiousness may be related to mental health, researchers need to unpick 'what it is about religiousness' that impacts on wellbeing in particular religions. In order to generate findings that are of use to clinicians, rather than using global religious measures, as most studies do, researchers should construct measures that measure theoretical aspects of particular religions (such as 'trust in God'). The study however suffers from sample bias: the number of Jews labeling themselves as 'orthodox' in the study was nearly 30% higher than in the general US population. It is possible that the higher the orthodoxy, the greater the trust in God. Further studies involving comparison between orthodox and non-orthodox samples is required to ascertain whether higher trust in God, arguably a characteristic of the more religious, is indeed a mediating factor in depression and anxiety. Also, comparisons with spirituality, where there is an absence of a 'trust in God', would allow for meaningful conclusions to be drawn regarding the relative impact on depression.

Cross-cultural studies

The positive effect of religiosity seems to have some cross-cultural validation. One study, carried out by Abdel-Khalek (2006), found that for a sample of over 2,000 Kuwaiti students, happiness, mental health, and religiosity are understood as one package, with very high co-variation. Although the temptation exists to generalise such a large sample to other Middle Eastern populations, we would do well to remember that Kuwaiti students are

probably more affluent and less religious than their neighbours. Findings may not therefore be generalisable across the Muslim world (Khalili *et al.*, 2002).

Abdel-Khalek and Lester (2006) went on to compare a sample of 274 US Christian and 460 Kuwaiti Muslim college students and found religiosity was positively associated with self - rating scores on mental health and negatively associated with anxiety in both countries. These studies however surveyed non-clinical college populations, so answers to questions of religiosity may be narrowed by sample characteristics. Future research should not rely on self-report measures, which may suffer from social desirability bias, a problem arguably more salient when samples are drawn from religious societies such as Kuwait and the US.

ANXIETY

Results for the positive effect of religion and spirituality on anxiety are slightly more mixed. Contrary to common misconception, clinical levels of anxiety and OCD were not found to be higher in religious individuals, in fact belief that one's fate is in the hands of a 'higher power' can serve to lower anxiety (Loewenthal, 2007). Although the literature suggests a positive link, further empirically sound research within clinically anxious populations across different religions and contexts is required to clarify discrepancies (Mansfield, 2008).

Research

A meta- analysis of 69 studies into anxiety and religiosity included 7 clinical trials and 62 observational studies (Koenig, George & Peterson, 1998). Even allowing for bias in observation, they found that 53 of 69 studies showed less anxiety among the more religious, while 6 of the 7 RCTs showed religious interventions for anxiety were more effective than secular interventions or controls. One RCT found that those consigned to a devotional meditation group had significantly lower stress and anger levels than those in a progressive meditation and a control condition (Carlson *et al.*, 1988). Again, these studies focused on Western religious contexts. Using a more Eastern approach to spirituality, Kabat-Zinn *et al.* (1992) found that a meditation intervention with 22 individuals with generalised anxiety disorder with/without agoraphobia, lowered anxiety and frequency of panic attacks. These results were clinically significant. This effect continued in 18 of the participants in a follow up study 3 years later. It is debatable however whether meditation can be considered a religious practice and whether rather, benefits received were purely physiological. The study is significant in that it is amongst a smaller minority conducted by psychologists.

In a prospective US Christian – based study, religiosity was found to predict greater mental health in a yearlong longitudinal study of people suffering panic-disorder by a group of psychiatrists (Bowen, Baetz & D'Arcy, 2006). While CBT and medication were effective treatments, individual coping mechanisms – including importance of religion – were significant in determining response to treatment. Improvement in symptoms in the '*religion*

is very important' subgroup continued to be marked over time. This study is important in suggesting that rather than religion being in itself a positive contributor to mental wellbeing; it is the enhanced perceived ability to cope with stress that religion brings that may be the determining factor. The use of only one question: *How important is religion to you now?* however limits the validity of the measure since it calculated religiosity at a single point in time. This may not represent the religiosity of the participants in general and may be measuring a response to worsened mental health in the form of panic disorder. Together with the small volunteer sample (n=56), which increases the likelihood of Type I errors, as well as the absence of a control group, results indicating clinically significant improvements need to be replicated in order to be supported.

Cross-cultural studies

El-Jamil (2003) compared Lebanese and American samples and found that religiosity buffered against both depression and anxiety, however the ways in which religiosity was constructed in each society was not unpicked sufficiently. When looking at 2,453 Kuwaiti Muslim adolescents, Abdel-Khalek (2002) found that religiosity negatively correlated with anxiety. This study relied on self-reporting, a source of bias. Other studies have argued that there is indeed no link between the two variables (e.g. Francis & Jackson, 2003).

Extrinsic and Intrinsic Religiosity

People differ in the way in which they are religious and this may have some bearing on their mental health. The difference between extrinsic and intrinsic religiosity could account for differential findings. Intrinsic religiosity suggests that religious belief guides behaviour and thought and is internalised by the believer, it is an end in itself, while extrinsic religiosity is instrumental and largely external.

Davis, Kerr and Kurpus (2003) found that participants with lower anxiety tended to have higher religious wellbeing and be intrinsically religious. Intrinsic religiosity has been found to buffer against anxiety, and religious interventions have thus proved useful in treating intrinsically religious clients with clinical anxiety levels (Koenig *et al.*, 2001).

Two prospective studies tested the stress buffering effects of intrinsic religiosity on depression and amongst 83 Catholic and Protestant college students in Delaware, USA (Park, Cohen & Herb, 1990). For Catholics, religious coping served as a buffer for controllable life stress, but as an exacerbator for Protestants. A slight decline in depression was found in Protestants with high intrinsic beliefs after uncontrollable negative life events, suggesting that intrinsic religiosity may bring meaning to negative events a few months later. The researchers argue that perhaps the structure of the Catholic practice of confession allows for alleviation of guilt “associated with “self-induced” life stress’ (Park, Cohen & Herb, 1990: 567). This finding was replicated in their second study, however like much psychological research, the study was conducted on college students as part of compulsory college

credits. Social desirability bias may be present in responses to questions about intrinsic religiosity. To its credit, the study recognised that the effects of the two belief systems on depression and anxiety may differ, however it assumed that Protestant belief systems are themselves unitary, ignoring the sub-denominations of Lutheran, Methodist, Baptist etc. The study also measured only across a few months and is thus not a truly longitudinal measure of intrinsic religiosity.

PROBLEMS WITH THE LITERATURE

It is difficult to come to definitive conclusions about the link between religiosity and depression and anxiety since they vary greatly in the ways in which they are measured across studies (Dein, 1996:42). Jarvis and Northcott (1987) point to the fallibility of the commonly used Index of Religiousness. Indeed, different measures could result in different findings, making comparison across studies unreliable. With so much reliance on self-reportage, social desirability and acquiescence affects measures of religiosity, impacting on the validity and reliability of data on people's religiosity (Spilka, 2002). This suggests that qualitative studies may be a better means of eliciting people's true beliefs and the impact on mental health.

Given that many studies are retrospective, much of the research basis is also correlational, therefore causation cannot be inferred. It is possible that the positive benefits of religiosity are related to a third factor, perhaps cognition, and this link needs to be researched further.

Furthermore, the conflation of religion and culture is such that their relative contributions cannot be quantified (Dein & Loewenthal, 1998). Given that religion is a product of particular cultures and is embedded in particular cultural assumptions, behaviours and attitudes it is impossible to generalize findings across cultures (Khalili *et al.*, 2002). Religion may have different meanings and impacts on mental health for different populations, and more cross-cultural research, particularly within clinical populations, is needed (Abdel-Khalek & Lester, 2006).

Furthermore, much of the evidence for the positive effect of religion on wellbeing does not come from randomised trials. Rather, studies tend to cross-sectionally view clinical populations, or extrapolate from non-representative community samples. The conclusion that for both clinical and community samples, religion improves mental health is by criticized by some, including Reisner and Lawson (1992). They argue that broad generalisations about the effectiveness of religion ignore the ways in which particular religions affect psychological makeup. They suggest that there are both helpful and unhelpful aspects of religion, and the difference in outcome may lie in whether believers are left with a feeling of shame or of grace. It is possible therefore that it is not so much religion per se that is having the positive impact on mental health, but the ways in which it is conceptualised, delivered and/or received by believers.

IMPLICATIONS FOR CLINICAL PSYCHOLOGY

The findings reported here suggest the prevalence and presentation of mental health problems and religion should be of concern to clinical psychologists practicing in a variety of cultural contexts. In the climate in which we practice, where religion continues to be of relevance to a large proportion of clients, clinical psychologists would do well to be cognisant of how their religious belief (or non-belief) impacts on the ways in which they interpret the beliefs of their clients, and vice-versa. In Iran, Islamic clinical psychologists, for example, work collaboratively with their clients to find a solution given the social and religious values of the individual (Khalili *et al.*, 2002). This proves very effective in a culture where religion defines private and public life. Given the evidence for religious interventions, clinicians may consider using culturally sensitive practices within psychological interventions. Furthermore, religious belief may function as a conduit for other psychological mechanisms. Psychologists will do well to study the ways in which this may impact on cognition and affect.

My position revisited

This review has forced me to consider how clients may make religious meanings of their experiences, and that these may be important to unpack in understanding, managing and recovering from their depression and anxiety. I have become aware of how intrinsic religiosity and particular aspects of religions may indeed impact on subjective wellbeing. I have also developed more sensitivity to, and respect for, the ways in which religion forms an integral part of people's culture and their mental health.

It seems to me that more psychological research into the role played by religion in the UK is required. Working within a diverse UK population, I have encountered people from a variety of African backgrounds for example, who hold beliefs from numerous religious traditions which current research does not address.

As a clinical psychologist, it behooves me to understand clients' phenomenological experiences and to make positive use of their religiosity in the formulation and in the therapeutic space. I am forced to reconsider the experience of the Jewish adolescent that I worked with. Generalisations that I made about his faith and wellbeing may have been incorrect. I now realise that religiosity is deeply subjective, and that in future it is my responsibility to understand each client's religiosity as unique.

MY THEORETICAL POSITION

Given the research, the theoretical perspective I now find most useful in my practice is a post-modernist one. This is because post-modernism might avoid declaring a definitive relationship between religion and mental health. It might suggest that religion and spirituality are intimately tied up with the culture in which they are expressed (Vanhoozer, 2003), and therefore allow for the effect of context in deciding how religiosity impacts on wellbeing. It is therefore difficult to know how much significance to attach to the loosely positive correlations demonstrated by the research. Religion and religiosity are instead understood as constructs of the society from which they come. All

studies are reflective of a narrow Judeo-Christian context and results may be reflective of these religions, rather than religion per se. Therefore in different societal contexts one might expect different relationships between mental health and religiosity.

CONCLUSION

Broadly, the studies suggest a positive effect of religion on mental health. Religion continues to be a source of a rich variety of meaning -making to those who experience it as an important part of their lives. The relationship between religion and mental health is however complex. Research needs to be conducted across a range of cultural contexts to generate data outside of what are largely US college samples. Furthermore, research may want to consider how religion is mediated by culture and how this impacts on mental health.

Because many people identify with spirituality being a core part of their lives and experience, it is important for clinicians to have some understanding of the meaning clients attribute to their spirituality and religion and of how this impacts on their mental health. If religion does confer some positive effects for mental wellbeing, it is imperative that clinical psychologists determine how this works and how this impacts on practice (Worthington *et al*, 1996).

Spirituality is a deeply personal experience, which can be crucial to understanding and healing mental illness. Leibrich, 2002, p.159.

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Professional Issues Essay

What are the differences and similarities in the process and content of supervision and consultation practices in clinical teams? How might we evaluate the effectiveness of supervision and consultation in our NHS work?

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INTRODUCTION

Remember what it was like to be a second year clinical psychology trainee? You probably knew something about supervision, but perhaps little about consultation. Since this is true of my clinical experience, I have based this essay largely upon supervision theory and literature, and frequently apply thinking about supervision to understanding consultation. This stance also reflects the traditional path of a clinical psychologist in the National Health Service (NHS), where she may provide supervision before becoming a consultant¹. The psychologist is also likely to bring her² clinical supervision experience to bear upon her consultation work (Sears *et al.*, 2006).

For me, placing supervision and consultation together in an essay question raises issues about the new ways in which I see psychology positioning itself within the NHS. The customary roles of a clinical psychologist are changing as the function and opportunities for supervision and consultation adjust within the NHS (*New Ways of Working for Applied Psychologists (NWWAP)*, Department of Health (DoH), 2007a). Indeed the DoH document *Working Psychologically in Teams* (NWWAP, 2007c, p.47) mentions explicitly that 'new possibilities are envisaged for the roles of psychologists'. This offers fresh challenges for how quality service delivery and practice is monitored and measured.

¹ I am aware that psychologists at every level are encouraged to consult, but that consultation may constitute more of the role for consultant psychologists.

² For ease of reference I have chosen to refer to clinical psychologists generically in the female gender.

The essay question is dealt with in three sections: the first places consultation and supervisory practices squarely within current NHS and other policies, arguing that there is a crossover between these two practices. The second addresses the similarities and differences in the process and function of supervision and consultation practices. The third addresses the challenges inherent in evaluating supervision and consultation within NHS practice and suggests design considerations for future research.

I will argue that the methodological problems inherent in quantifying outcome measures of supervision and consultation are similar and that there is much commonality between the practices of consultation and supervision in both content and process. I will also contend that the paradigm shift spearheaded by the NWWAP documentation is bringing them even closer. I focus on how supervision and consultation are alike while recognising that differences are subtle but important, particularly in engagement, time frames and the role of responsibility and power within the relationship.

My position

I am aware that by taking an overarching view of both consultation and supervision, individual approaches (e.g. family systems, psychodynamic) are not addressed. I also concentrate predominantly on the processes of supervision and consultation for clinical psychologists (rather than for other team members). These decisions were taken because, as a trainee new to clinical practice, I am interested in understanding supervision and consultation

in the NHS from the perspective of the clinical psychologist. Furthermore, while I am aware that service-users are the recipients of NHS services, since this essay deals with consultation and supervision, its focus on 'clients' is on those directly receiving those services i.e. staff.

1. New Ways of Working Psychologically – Supervision and Consultation

There is fluidity in the ways in which the terms *supervision* and *consultation* are used in the new DoH NWWAP documentation (2007a; 2007b; 2007c). Indeed 'peer consultation' and 'supervision' are employed almost interchangeably, appearing together numerous times, and littered across contemporary NHS policy (e.g. DoH, 2003; DoH, 2007b; 2007c).

This apparent shift in professional mindset extends to local NHS level. For example, in order to ensure effective care pathways within the learning disability (LD) service in which I currently work, psychologists are explicitly required to liaise with other mental health practitioners across the Trust through providing both supervision and consultation on LD issues (Sussex Partnership Blueprint for Under One Roof (BUOR), 2010, p. 6). The policy describes a more flexible community approach to service delivery whereby teams are no longer deemed as finite units, but where specialists (like psychologists) offer consultation across, within and between teams. The (2003) Supervision Guidance for Supervisors document led this thinking in the provision of new psychological services:

*The importance of supervision and peer consultation for psychologists
... cannot be overestimated (DoH, 2003, p. 13).*

Supervision and consultation are thus intrinsic to the role of the clinical psychologist practicing in the NHS today (DoH, 2007a; BPS, 2007; Health Professions Council (HPC), 2009). Both rely on the specialism brought to the team or service by the psychologist (NWWAP, DoH, 2007c), while supervision is considered one of the Ten Essential Shared Capabilities of Mental Health Practitioners (DoH, 2004).

With an emphasis on the integration and embedding of psychologists and psychology into the life and work of teams, comes a focus on providing supervisory and consultative opportunities (NWWAP, DoH, 2007c). This includes providing supervision and consultation to front-line staff so as to '[create] the right conditions for effective user and carer participation' (DoH, 2007c, p. 32), as well as facilitating service-user consultation to teams. For me, this places psychologists in an interesting position within NHS systems, somewhere on a scale of integrating fully by offering supervision and consultation within their teams, while remaining somewhat separate, supervised by local psychology services, consulting outside of the team (DoH, 2007c), and liaising with service-users on quality of service provision.

The idea that the psychologist is 'the consultant in the system' (Roberts, 1998), a third person in a consultee/client, supervisee/client relationship, who is well positioned to consult and supervise on a one-to-one basis, through peer consultation, or by giving a team a space to think, is a position that I have already taken up. For example, I was able to use the skills that I acquired in supervision (reflecting, questioning, paraphrasing, listening, formulating) to facilitate staff discussions around difficulties experienced by a woman with a moderate LD and experiencing severe anxiety. It was the first time I was able to reflect that supervision and consultation practices can be viewed as on the same continuum, and that the skills required for the latter are not dissimilar to those learnt in the former. Subsequently I have assisted a number of paid and unpaid carers in reflecting on and reframing the experiences of the service-users they care for. These experiences have allowed me to make better sense of the thinking in the new NHS documentation (e.g. NWWAP, DoH, 2007).

2. Comparing Supervision and Consultation

What is it about supervision and consultation that suggests they are similar practices? Consultation was long ago defined as a voluntary relationship between two professionals, initiated by the consultee (Caplan, 1970 in Caplan & Caplan, 1999). The intention was to solve a problem involving a third party by increasing capacity within the consultee and by helping to generalise skills to similar situations (cited in Brown *et al.*, 1991, p.6). Understood like this, consultation is not unlike supervision in both process and function. Consultation too involves a

triadic, mutually involved relationship, based around a problem, and designed to prevent its reoccurrence, as well as enhance independence (Parsons, 1996).

It seems to me then that both practices involve a dyad working together on issues relating to the (usually absent) third member of the triad (the service-user). Both involve relational processes enhancing change (Parsons, 1996). While both supervision and consultation prioritise the service-user's experience, my supervision has also been concerned with theory, my development and with personal reflections. However consultation was traditionally conceptualised as service-user and skills-focused (Caplan & Caplan, 1999). I wonder whether this distinction is becoming less clear with the changes in NHS NWWAP documentation?

Function

Through modeling and teaching reflective practice skills, both supervision and consultation provide the possibility of observing interactions with others and becoming aware of alternative ways of thinking about relationships with service-users and carers and within teams (DoH, 2007c). This suggests to me that supervision and consultation are serving similar functions, and that differences exist rather at the level of scale. That is, supervision is usually delivered to one or a few supervisees at a time, while consultation may involve a whole team. It also suggests that clinical psychologists are unique in being able to model using formulation about service-users in both consultative and supervisory thinking.

I have witnessed how clinical psychologists reflect on service-users' experiences within team meetings, challenging defensive practice, as well as enhancing

communication (DoH, 2007c). For example, in LD team meetings they challenge deterministic and risk-averse thinking in other staff.

I have reflected on how this process is similar in purpose and procedure to my experiences of being in supervision. This has demystified consultation for me. With experience now of a number of supervisors, I have learnt how the supervisor's job is flexible, responding to the needs of my clients and to my developing needs as the supervisee (Parsons, 1996). In the LD service I have noticed that while the primary function of any consultation is often a particular issue such as behaviour management, supervision may have a wider agenda and is often concerned with more generic reflections and skills-building. This suggests that the service has not as yet fulfilled the expectations of NWWAP.

Since current DoH documentation emphasises the saliency of supervision and consultation for applied psychologists, this distinction is becoming less clear and the difference in function between the two practices less discernible (NWWAP, DoH, 2007a; 2007b; 2007c). The original definition of consultation focused on the consultee's knowledge, skills and ability to remediate and prevent problems (Parsons, 1996, p.27). Supervision was initially seen as a "spread of effect" as information seeps from supervisor through supervisee to client (Gallessich, 1982). The new supervisory function is rather the provision of a facilitative space for reflection on how people practice, aiding insight (Parsons, 1996). Similarly, Sears *et al.* (2006) argue that in contemporary consultation, psychologists support organisational change through teaching reflective skills that improve the consultee's capacity to manage a particular situation, rather than impose

predetermined solutions. Psychologists can also offer consultees an opportunity to reflect on their feelings about service-users (Lake, 2008), much as they do in supervision.

Process

Is the process by which consultation and supervision delivered also similar? Fruggeri (2002, p.3) focuses on the 'generative and transformative process' by which people acquire new skills in supervision. The supervisor's job is to help the supervisee to reflect on the 'processes' and 'patterns' that are created within supervision and with/within the service-user (Worthen & Lambert, 2007). Supervision has provided an invaluable experience for me in my current placement in providing a safe space to reflect on my preconceptions about the client group. I am also aware of how my supervisor has carefully built up my confidence and aptitude over the course of the placement to work with some non-verbal service-users (Worthen & Lambert, 2007, p.48).

Consultation too offers these opportunities (Parsons, 1996). By focusing on the reflective practices of consultation, Lake (2008, p.15) suggests that consultation is not unlike supervision in that it is a process

to review what is going on in the work between a staff member (or team) and a client, in a way that is informed by an open, enquiring, reflexive and psychologically informed approach to the work.

Fruggeri (2002) highlights the process of supervision as including first a description of the problem, then a consideration of the 'characters' in the situation and how they interact, reflecting on how the client and supervisee relate, and lastly a deliberation on the effect of change in the client on the rest of the system. This produces an analysis of 'the dance performed together by all involved' (Fruggeri, 2002, p.17). I believe that if one rereads this as a process description of consultation, it would adequately define consultative processes too. Consultation too involves an analysis of the behaviour of the people involved, their relationship and a consideration of how this might alter should change be brought into the system.

Of course process and function do not act independently and models of supervision may intertwine process with content. Inskipp and Proctor (1993) suggest that supervision can fall into any of three categories: formative, normative or restorative (Scaife, 2006). A formative supervisory function emphasises supervisee's learning and development, and may be the focus of a consultative process too if consultees are looking to develop skills. The normative function of supervision is more about the ethical and managerial responsibility that the supervisor takes in relation to the supervisee. Its function may differ somewhat in the consultative relationship however whereby responsibility remains largely with the consultee. The restorative supervisory function relates to the emotional reaction of the supervisee to her work and to her client. In consultation, teams too are being encouraged to reflect on their 'benign' and 'malign' experiences of power for example (NWWAP, 2007c, p.24).

While both supervision and consultation are concerned with the process of developing capacity and confidence (Parsons, 1996), I believe there exists some difference between the processes of engagement, particularly for trainees. Where therapists are obliged to negotiate appropriate supervision to learn skills, there exists no such imperative to seek consultation. Consultation is rather a matter of consultee choice and may be motivated by a moral obligation to the client, whereas supervision is a statutory requirement (e.g. BPS).

Responsibility

In order to gain further insight into consulting, I also interviewed a consultant clinical psychologist³ in my current service. She highlighted an important distinction between supervision and consultation arguing that the difference is one of responsibility. She saw this as both content and process-based. In the consultative relationship she felt that there exists no expectation that she should bear responsibility for the implementation of suggestions. However this was obviously not true for supervision, particularly of trainees since they are deemed to be learning.

This differing approach to the sphere of influence of a supervisor and a consultant is borne out by theory. Caplan and Caplan (1999) argue that within supervision there exists at least some expectation that advice given will be adhered to, whereas in consultative relationships, there is no obligation that the consultant's

³ The consultant wishes to remain anonymous and is therefore not referenced.

suggestions will be accepted. In fact, they suggest that one of the defining characteristics of the consultation relationship is that the consultant bears neither administrative nor professional responsibility for the outcome of the consultee's case. The consultee retains primary responsibility for implementing ideas stemming from consultation, and indeed the right to accept or reject advice (Wynne *et al.*, 1986, p. 3) and should always understand that they can do what they wish with the consultant's advice (Kratochwill & Pitman, 2002). Unlike with supervision, feedback and follow up are not expected.

In my experience of supervision, I understand responsibility as being intrinsic to the process of supervision. The supervisor is responsible to her supervisee in so far as she is expected to provide useful, valid knowledge, skills and reflections within supervision and to guide ethical practice. She also bears ultimate responsibility for the trainee's clinical decisions. Qualified staff are however responsible for their own clinical decisions in a similar fashion to consultees. The supervisee is responsible to the supervisor in so far as she should relate honestly any relevant clinical and personal information, as well as to carry out suggestions negotiated within supervision to the best of her ability.

The consultant I interviewed also saw responsibility as being a product of the ongoing relationship of supervision. She believes that the supervisor is at least partly responsible for the progress and development of trainees in particular. In consultation, the expectation is of a shorter, discrete piece of work, from which she withdraws responsibility quite quickly. Caplan and Caplan (1999) agree, arguing

that dependence is not fostered in consultation work and that the relationship is often briefer and more focused. This suggests a difference in the content and nature of the contract negotiated and the way in which the parties may approach the particular relationship.

Within consultation then, responsibility for decisions and implementation lies with the consultee, there existing no 'predetermined body of knowledge' that the consultant wishes to impart (Wynne *et al.*, 1986). In supervision, autonomy is arguably curtailed as the supervisee is expected to consider prior knowledge as she learns from someone more experienced.

Control and power relations

Both consultation and supervision therefore involve a negotiation of power between parties (Sears *et al.*, 2006). In consultation the consultant has no direct control over the change process (Illback *et al.*, 1992). However since supervision is often delivered by someone with more experience to someone with less, a supervisor exercises authority over the supervisee and may hold evaluative power. Some theorists (e.g. Gallessich, 1982) have argued therefore that a 'non-threatening' relationship can never be fully achieved within supervision, differentiating it from a consultative one, which strives to be egalitarian in nature. Parsons (1996) however contends that a consultant is approached ostensibly because she is believed to hold some expertise and that this expertise inexorably grants her some power, while Brown *et al.* (1991) focus on the democratic nature of consultation and contrast it with the somewhat authoritarian and evaluative relationship customary in supervision.

I have experienced supervisory relationships that are based on equality and co-construction of change (Anderson & Swim, 1999). This made me feel valued and skilled. I have also experienced more didactic supervision, which undermined my confidence and autonomy. I believe that consultation, which highlights staff's abilities and encourages negotiation of solutions should therefore facilitate better outcomes. It seems power and responsibility within the consultative and supervisory relationship lies in the way that control is interpreted by individual practitioners, rather than in anything intrinsic to the relationship or practice itself. By expecting psychologists to consult and supervise across teams and systems (NWWAP documentation), new areas of responsibility and of power relations will open up and these will have to be negotiated.

Summary of Comparison between Consultation and Supervision

There is similarity in the ways in which supervision and consultation are being defined and conceived within contemporary NHS psychology. Both practices value reflection and aim to develop capacity. While there exists a difference in the scale of intervention and level of autonomy, the scope of the agenda as well as its content is becoming increasingly similar. Differences in the ways in which control and power are interpreted depend on the individuals involved rather than on the nature of supervision or consultation themselves. A key distinction however may exist at the level of responsibility for decisions taken, particularly when involving the supervision of trainees.

3. Evaluating Supervision and Consultation in the NHS

The NHS is committed to effective supervision as it has been found to ensure safe and effective practice, as well as maximise client outcomes (Milne, 2009). Clinical Governance is tasked with monitoring the quality of both consultation and supervision provision, while the Healthcare Commission supervises standards (NWWAP, 2007b; 2007c). However, as Donabedian (1988) recognised, evaluating service delivery is a complex task involving an understanding of the scope of quality care, the relationships involved, a consideration of what is to be measured, and how to define terms and outcomes. Though the NHS has developed guidelines for conducting reliable research into service delivery (NHS Executive, 1996), evaluating supervision and consultation effectiveness continues to be affected by conceptual, design and pragmatic concerns. I will now address some of these methodological concerns and then offer suggestions for more reliable measurement common to both consultation and supervision.

Definition

In order to reliably measure effectiveness, the concepts of what good supervision and consultation need to be translated into reliable quantifiable measures on an ordinal scale at least (Donabedian, 1988). Little agreement seems to exist however about definition and what to measure in the complex processes of supervision and consultation, making service evaluation more difficult than is implied by optimistic NHS documentation (e.g. NWWAP, 2007b). For example, a review of 144 empirical studies of clinical supervision (Ellis *et al.*, 1996) concluded that hypothesis testing was not sufficiently well defined initially, meaning that

supervision could not be adequately measured (in Milne, 2009). This picture is evident across much of the literature into service evaluation.

Design

Design flaws are also endemic. Milne and James' (2000) review of 28 papers of supervision effectiveness, accused many of these studies of lacking empirical rigour. This explains in part why Grant and Cavanaugh (2007), in their review of external consultation efficacy, argue that there are no Randomised Controlled Trials (RCTs) in the area. This remains the current state of consultation outcome measures in the US also (Kilburg, 2010).

The reality of practicing within health services also means that drawing on proven methods that are also tailored to meet client's requirements is unfeasible (Kilburg, 2010). In reality, supervisors, consultants and service-users and carers discuss, gather data and design interventions, conduct action research and then critically evaluate their work and its outcomes (often retrospectively). This process is open to many of the design flaws that are customarily the bane of pragmatic research tools, such as researcher bias, and methodological compromise.

As a result, in their discussion paper on supervision for the Division of Clinical Psychology (2003, p.6), Green and Youngson argue that while all clinical professionals would agree that supervision is important to clinical work, 'there is no established evidence base for its efficacy'. This applies, they say, to whether we are addressing service-user outcome, overall service delivery, or improvement in

clinical practice of supervisees. Therefore, in spite of the difficulties inherent in its use, Green and Youngson (2003) suggest including qualitative approaches in supervision evaluation. These include evaluative components in the design of supervisory services, as well as reflective writing and opportunities for sharing of good practice. In fact, in the absence of reliable quantitative means of evaluating supervisory and consultative effectiveness, the BPS (2003) advises using descriptive means to share good practice.

Measurement

Given the variety of understandings of both consultation and supervision, a further problem with evaluation is with inconsistency of measurement. Here quantitative measures may prove more useful. For example, in a review of over 50 studies measuring supervisory effectiveness to demonstrate reliable change within the trainee (Lambert & Ogles, 1997), the most useful measurement involved observable trainee behaviours and those studies where the trainee was evaluated on a number of quantifiable measures. Though this review allowed for a measure of internal consistency, external validity of supervision could not be established as the reasons for trainee change were not measurable, nor were service-users outcomes consistently quantified.

A number of self-report supervision measurement tools exist (e.g. Supervisory Styles Inventory⁴; Supervisee Perceptions of Supervision⁵) but all suffer the concomitant problems of this methodology. Self-report tools would also constitute

⁴ Friedlander & Ward, 1998.

⁵ Olk & Friedlander, 1992.

a lowly Type IV support-base on the NHS hierarchy of evidence (Evans, 2002). In the absence of RCT validated studies however, Donabedian (1988) would argue that self-report would however represent 'expert' opinion, and that it would therefore constitute some good evidence.

Client outcome

Few studies relate the skills gained in supervision however to client benefit (Holloway & Neufeldt, 1995). 'Although client outcome is considered the acid test of supervision efficacy (Ellis & Ladany, 1997; Stein & Lambert, 1995)', Falender and Shafranske (2004, p.202) claim that 'to date we do not have clear, methodologically sound data on client outcome and its relationship to supervision'. In a 1995 review for example, supervision seemed concerned more with the interpersonal relationship with the supervisee than with client outcomes (Holloway & Neufeldt). This contradicts the expectation that we, as clinical psychologists, should facilitate the inclusion of service-users and carers in service delivery and research (BPS, 2006). Worthen and Lambert (2007) complain that although other areas of the supervisory relationship are measured and measurable (adherence to the model, supervisory alliance), the outcome for clients remains the least measured. This appears equally true for consultation and poses methodological challenges for clinical psychologists' ethical practice.

What can be done to ensure meaningful service evaluation?

While the new NWWAP calls for evaluation of consultation and supervision, any service evaluation undertaken at local level should therefore include patient

outcome measures and progress monitoring as standard (Worthen & Lambert, 2007).

Particularly in the area of efficacy evaluation, studies should contain explicit definitions and pre-determined outcome measures for both service-user and consultee/ supervisee (Smaby *et al.*, 1994), and service-users and carer participation should be viewed as standard. Ideally, each phase of the consultation/ supervision process should therefore be evaluated using specifically designed measures, whether quantitative or qualitative, and the methodological flaws of each should be taken into account. Effective evaluation may therefore include aiding the consultee (supervisee) in a detailed and complex recording of their and the service-user's experiences of the process, using debriefing to facilitate self reflection, and conducting follow-up interviews with service-users and consultees. I am cognisant that within a resource-strapped NHS, well-designed effectiveness studies might be a luxury. In fact I have yet to come across any in my NHS work. The dearth of research goes some way in explaining the importance of trainee clinical psychologist's Service Related Research Projects (SRRP) conducted in NHS services and the grateful way in which they are greeted by busy clinicians.

Compromises at local level

The pragmatics of time-consuming resource-heavy methodologies may rather necessitate a single pre-intervention post-intervention client measure (Barker *et al.*, 2002), a method adopted by many trainees in their SRRPs. If the intervention

necessitates measurable differences in a service-user's behaviour or a staff team's function, this is easier to quantify, however this may be less pragmatic in services like LD where change may not be quantifiable.

Outcome evaluations often rely on staff or client self-report satisfaction questionnaires however. Trusts should be aware that self-reports of consultation and supervision may suffer problems of validity and reliability, and may miss out on qualitative detail. Also, psychologists are well positioned to remind managers that since many factors influence the efficacy of supervision/ consultation, outcome studies can never make definitive statements about causation (Donabedian, 1988).

Trusts may have their own means of evaluating practice. Sussex Partnership Trust has committed itself to put in place systems to continuously, formatively and summatively evaluate and monitor clinical practice, as well as safeguard standards of care set at national level (BUOR, 2010, p.12). It sees supervision as part of this strategy. All post-qualification psychologists are therefore committed to supervision training - a one-year internal accreditation and evaluation of the quality of supervision, regulated by the achievement of core generic supervisory skills (Supervision Governance Group (SGG), 2009). The SGG then independently assesses whether the applicant has met the core competencies to become an accredited supervisor. Furthermore qualified supervisors are required to receive supervision of their supervisory practice, marked against a further competency list based on the Roth and Pilling (2007) supervisory framework.

Alternatively, local services could conduct an audit to evaluate practice. This involves taking an in-depth look at an aspect of consultative or supervisory practice, compare that to accepted standards that have been formalised in trust policy and feed-back into improving the service (Barker *et al.*, 2002, p. 201). A qualitative 2002 audit of adult service-users in East Sussex Mental Health Services (ESMHS), who were exposed to consultation and supervisory skills, showed increased empowerment and self-narrative, as well as improved ability to make positive changes in their lives (NWWAP, 2007c). Service-users benefited from systemic-type consultation involving professionals from a variety of backgrounds. This then informed ESMHS practice.

The service in which I work is also currently involved in auditing outcome measures. While not a measure of supervision or consultation as such, every intervention will have been influenced by these practices since all staff involved will receive supervision and/ or consultation. I am aware however that the measurement tool involves a single pre and post-intervention scale, and is thus incapable of quantifying the real impact of supervision/ consultation or of capturing the nuanced changes typical of LD populations.

CONCLUSION

Measuring supervision and consultation effectiveness is complex, with design and outcome measures suffering methodological deficiencies. In my experience, I feel that the success or failure of any consultation or supervision can only be measured qualitatively as it is a product of a complex process of relationship-building

(Tingstrom *et al.*, 1990) and a negotiation of power and responsibility. Efficacy measures would have to capture nuance and would therefore be difficult to design and implement. Furthermore, quantitative measurement tools of supervision and consultation may not adequately reflect what causes change in service-users.

While supervision 'cries out for study and enhancement ' (Milne, 2009, p. 1), without a unifying definition or theoretical model of either supervision or of consultation, they will remain problematic to measure and to compare (Rodenhauser, 1997). Evaluation of consultation and supervision practice would therefore benefit from explicit definition of goals at the outset, set against NHS-specific criteria, so that performance can be measured prospectively (Kilburg, 2010). I realise however that indirect measures of efficacy are often the best evidence available.

There are many commonalities between supervision and consultation and indeed the former seems to inform the latter, both in process and in function. If supervision and consultation are viewed as psychological practices on the same continuum, as is suggested by the latest DoH NWWAP documentation, solutions for evaluating supervision could be applied to consultative practices.

Collaboration, consultation and supervision are increasingly important processes within psychology. The competencies involved in consultation and supervision overlap within mental health practice (Sears *et al.*, 2006, p.9), and the line between them seems to be becoming increasingly blurred (with NWWAP, 2003, 2007a; 2007c). The ways in which standards of supervisory and consultative care

are similarly conceptualised and delivered, as well as outcomes measured, may indeed bring the practices of supervision and consultation ever closer together.

Given the new challenges faced by psychologists practicing within the NHS, it remains to be seen how effective the evaluation procedures of local services, Trusts and Clinical Governance bodies will be. With the methodological and resource problems posed by rethinking the ways in which we work psychologically, delivering effective supervision and consultation may be a useful measure of the efficacy of clinical psychologists, of teams and of systems.

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The Relationship to Change:
Problem Based Learning Reflective Account

November 2009

Year 1

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INTRODUCTION

Schon (1982:50) talks about 'knowing-in-practice' as a deliberate attempt to understand how mental health practitioners' professional knowledge interplays with their personal and clinical experience. This essay is an attempt to use 'knowing-in-practice' to explore the interplay between Prochaska and DiClemente's Cycle of Change model (DiClemente, 2003) and my experience of a personal and professional development (PPD) group task. This is in the context of beginning training as a clinical psychologist.

The 'original problem'

In our PPD groups of eight, we were tasked with discussing our 'Relationship to Change' and then presenting the fruits of this discussion to the rest of the cohort. Within the group, uncertainty reigned as to how to deal with this problem. I would contend that uncertainty continues to be a pivotal theme in the ways in which we engage with each other, however it is lessening as we learn to trust one another. This uncertainty pertains, at least in part, to the knowledge that I, and I think others, are aware of the importance of needing to change within ourselves in order to become 'reflective practitioners'. Acquiring the self-awareness that is required to understand how personal beliefs, assumptions and experiences impact on the therapeutic relationship is difficult and challenging. The last time that I was encouraged to look at myself in this way was when I was studying drama directing. In much the same ways as actors draw upon their past, their values and perceptions, the therapist

uses her self-knowledge to understand how client's phenomenological experience is similar and different to hers. I am finding acquiring this self-knowledge very painful.

The group process

The use of theory in the PPD group's processing of the task was erratic. While initially it formed a central part in organizing discussion, it later waned as members became more confident in forming and then articulating their own tentative models of change. However, we decided to shape the presentation around Prochaska and DiClemente's Change model, and thus this theory impacted on the ways in which I began to understand change in myself and in my clients. The model formed the basis on which I made sense of change over the initial weeks of the course, and has since shaped and formed my understanding of change processes amongst my clients.

The PPD exercise represented our very first experience at doctoral level of a synthesis between theory and practice. Both our initial and later reliance on theory suggests an attempt to use it as a source of security. I am aware that even in this reflective account, I am invested in using theory to frame the piece of work. Much like Freud's concept of 'intellectualisation' (Eysenck and Flanagan, 2000), our reliance on theory may have been an attempt to distance ourselves from the anxiety elicited by our own experience of change brought on by starting the clinical doctorate. Perhaps it is also a reflection of the importance placed in undergraduate and postgraduate study on evidence,

rather than on personal reflection. It is also understandable, given that the group met initially on the very first day of the doctoral program; a day characterised by heightened anxiety. Theory provides me with a perceived sense of security.

How the group carried out the task

I was relieved when volunteers took up the roles of scribe and chair. The latter role was felt by many to be a particularly unnerving one, given the uncertainty palpable within the group. Also, the focus of a chair allowed the group to place responsibility elsewhere than themselves. I purposefully refrained from undertaking either role as I was aware that I would have used both as a means of deflecting attention away from myself, and therefore I would not have contributed to the group.

I found the first four meetings of the group uncomfortable, particularly because of feelings of alienation as a result of my age and nationality. I am both older than the rest of the members as well as from a foreign country. Many of the cultural assumptions inferred by members of the group were lost on me, increasing my sense of aloneness. As with clients in a therapeutic environment, trust is the cornerstone on which change can happen. For me, as for clients, the development of trust is ongoing: I feel now that I could disclose what I could not in September. However the limited level of intimacy is such that there are many aspects of both myself and my clinical work that I would not, as yet, feel comfortable sharing. I am also cognisant of the parallel with a particular client; while impatient for her to reveal herself to me after less

than ten sessions, I am aware that disclosure and trust are necessarily processes not fixed points.

PROCHASKA AND DICLEMENTE'S CYCLE OF CHANGE MODEL

With hindsight then, I am able to apply the stages of Prochaska and DiClemente's Model of Change to all areas of change that I am experiencing in training. I will look at each of the stages individually (precontemplation, contemplation, preparation and action) and relate them to the various areas in which I am experiencing change:

1. Precontemplation Stage

My initial reticent responses to the group provided me with an opportunity to see how clients experience services for the first time. I did not initially acknowledge that I needed to compromise in order to meet the needs of the group. In much the same way, clients often have difficulty in acknowledging that they may need to change.

The precontemplation phase lasted for most, if not all, of the PPD task period. The group worked at a fairly superficial level and, while functional, conversation lacked depth. This may be related in part to the youth of many of the members and also to our failure to raise superficiality as an issue.

I have noticed that it takes quite a number of sessions for clients to honestly engage with therapy too, and to begin to work at a deeper level. For example,

one client is only beginning to talk of difficult childhood experiences after ten sessions. Some clients seek therapy because they are ready to change but require support; others are unaware of their need for change and believe that therapy means that the onus lies with the therapist to instigate change. While the first group may have reached the stage of contemplation, I have found the latter is more difficult to motivate. I have one client attending therapy because of family pressures. She has not yet realized that in order to shift the depression, she will have to take responsibility for making changes to her behaviour and cognitions. She remains in the precontemplation stage. I can relate this to the realization that I had late in the group task that, should I be dissatisfied, it was up to me to instigate change. With clients, this stage raised my first ethical dilemma: do I risk destabilizing them further by initiating unwilling change or leave them in the precontemplation stage if they are not ready to engage in therapy?

The precontemplation stage is characterised by ignorance. Prior to starting the course and the PPD group, I was unaware of the many professional challenges changing roles would initiate. I was ignorant also of the commonalities and differences between my past role of teacher and my new therapist role.

2. Contemplation Stage

This stage began towards the end of the task, but solidified only once the PPD group task ended and is a reflection of my global integration into the course and cohort. I began to understand that in order to integrate fully into

the group, as well as to benefit from the group process, I would have to be more explicit about my needs of the group and of discussion. For the first time I was able to share some of my fears about the course.

As a group, we recognised late in the PPD task development that discussion was either theoretical or superficial, and that personal reflections and application to professional development was missing. In order to enjoy the benefits of bringing the agenda (and presentation) to a deeper level, we would have to be more trusting of the group's cohesiveness and confidentiality.

Like me, clients in this stage show reticence to leave learned behaviour behind. Some clients do realize however that the negation of change is an underlying maintenance factor. I think that one woman's depression worsened when she realized that she is responsible for her own change. When clients realize that the cause of some of their suffering is not external, they can imagine control over future experiences. Change becomes possible. However both clients and I had little knowledge at this stage about how to help them engage in alternative behaviours or thinking styles. This left me feeling deskilled.

Some self-exploration led to a realization that some of my skills are transferable (including the ability to empathise and to simplify complex psychological material, as well as to synthesize the abstract and practical), however I was still not keen to reject my 'teacher' role. I realized that the

teacher persona was informing the way that I delivered CBT to clients - I was being didactical and not sufficiently collaborative.

3. Preparation Stage

As the allocated task time passed, I began to spend time thinking about how to engage more with individual members of the group, as well as beginning to disclose within the group. I attributed my previous reticence to insecurities around acceptance and a very real fear of being rejected by the group. This fear continues. In the meantime the group was tentatively disclosing personal experiences and beginning to discuss our genograms, with rules regarding confidentiality in place.

As for group members, so for clients: a trusting relationship allows for consideration of change within the supportive therapeutic space. To stimulate change for clients, I focused on smaller areas that can be more easily modified, for example simple activity scheduling with a depressed client.

As regards supervision, I am now engaged in new ways of addressing the supervisory relationship, including more frank discussion. This is making me less anxious about the relationship. I am also beginning to cast off my old role and tentatively embracing the role of clinical psychologist. I am questioning myself a lot about what it means to be a clinical psychologist and becoming aware of the profession's personal, professional, ethical and political values and what they mean to me. I am asking myself what it is about the profession that drew me, and what changes I will need to make in order to

embrace it. This is a difficult and emotional process and I feel it is often an individualistic and therefore lonely journey.

4. Action Stage

This is the current stage with regards to relations within the group. In order to get to it, I used the CBT model and a Thought Diary to understand my negative reaction to group processes. I found it very useful in uncovering negative automatic thoughts (NATs) about not belonging. I have disclosed my fears about not belonging to the group in an effort to combat these thoughts. I have realised that dealing with my anxieties about belonging to this (and the larger) group will be a key challenge for me for the duration of this course. Motivating and maintaining change (action) in clients will be the other one.

CONCLUSION

Theory has shaped the ways in which I understand my relationship to the changes I have had to make to encompass my new roles as professional and student. My desire to change, despite how hard it has been, is motivated by the positive feelings I have about the values that lie behind the profession of psychology in the UK. I have evidenced and admired these values in the professionals I have been working with, and want to emulate them. I hope that theory and practice – 'knowing in practice' - will continue to inform me as I continue to change.

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Problem Based Learning Reflective Account

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Year 2

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INTRODUCTION

As an introduction to our second year of clinical training, each PPDG (Personal and Professional Development Group) was tasked with discussing a PBL (problem based learning) case study and then developing a presentation in relation to the issues raised. The PBL centred around a couple with learning disabilities (LD) who were threatened with having their children removed as a result of their perceived inability to parent.

For me it was both fortuitous and interesting that I was concurrently on an LD placement. This enabled me to apply learning from the microcosm of the PPDG and the PBL, to my experience of working with clients with LD and their families and carers, and to related systems within the NHS. Through the PBL task, I also became more interested in both systemic and psychodynamic models, applying them to the task as well as to my work within the LD service.

Approaching the problem

The PPDG decided to explore the PBL systemically because we felt that the problems raised by the case study were rooted within various systems (family, social welfare and societal). Using circular questioning within our presentation was therefore appropriate. After considering different formats, we felt that a role-play was a suitably respectful vehicle for portraying the difficulties experienced by the clients. It also allowed us to participate in and demonstrate our understanding of both systemic formulation and psychodynamic reflection, broadening our understanding of both models.

I was interested in how a systemic model facilitated a different approach to our learning. It allowed us to think about the PBL more collaboratively. We were more tentative and reflective (Dallos & Steadmon, 2009) than we had been in our previous presentation. We reflected that systemic thinking might be a beneficial way of working with families and staff teams around people with LD, seeing problems as lying within relationships and patterns of relating, rather than within individuals.

I have discussed with my supervisor how I see the discourses around LD operating in society. I have also discussed how these discourses impact negatively on how clients manage their own LD (Sinason, 2010). Realising that psychological issues operate as more than just intra-psychic processes has been one of the most valuable insights I have gained from any other person in my PPDG. It has also influenced the way that I work with my clients in the LD service. For example, I now take societal and family systems pressures into account when formulating.

Bringing thinking about the negative discourses surrounding people with LD to the PBL was perhaps my most valuable contribution to the task. For example, the theory of 'secondary handicap' (Sinason, 2010) suggests that people with a LD are further disabled when they take on behaviours that suggest they are less able than they really are. I helped the group realise that the couple in the case study might be viewed by social services as being unable to care for their children as the pair might be demonstrating secondary handicapping behaviours in the face of an intimidating court and social welfare system. Like

the couple, I have worked with clients with LD who have learnt that 'dumbing down' their intelligence protects them from psychological pain (Sinason, 2010), but may result in other difficulties.

I further introduced into the task the idea of cognitive biases and discourses as defenses against thinking about the difficulties experienced by the client group (Sinason, 2010). I reflected that we might be approaching the task in such a way as to view the couple as culpable for their situation so as to make unpleasant feelings about LD more palatable to ourselves (Valliant, 1971). In discussing the PBL, we may have found it difficult to think about the clients' pain at having their children removed, and thus were initially able only to think of reasons why they would make inadequate parents. It took time for us to consider their merits as parents. This challenged the group's desire for certainty in ensuring the children's safety and later formed an important part of the presentation.

This realisation allowed me to think about how I brought psychodynamic defenses to bear on the task. Sinason (2010) describes how people with LD are acutely aware of their own disabilities. This concept was very hard for me to process as I found comfort in believing that clients with severe LD are unaware of the extent of their disability. The idea that they experience extreme distress in understanding their own difficulties made me very anxious when thinking about and working with a woman with profound needs. I used the PBL task as well as supervision to process these feelings. I later realised

that my experience of the counter-transference was very powerful (Lemma, 2006).

Defenses were active from the start of the PBL process. The group developed a checking-in system at the beginning of each meeting. This became progressively longer, often populated with superficial talk. Humour acted as a type of manic defense (Lemma, 2006), and sometimes we were unable to 'hold' difficult emotions like shame and disgust in relation to the client group (Bion, 1967). We discussed how meaningless conversation might be a defense against deeper processing of the task and about painful feelings about LD in general (De Board, 1997). We also talked about how the group might be suffering secondary unconscious mechanisms (Bion, 1967) in order to avoid the primary task of addressing the PBL. This discussion was also included in the reflections at the end of the presentation.

THE PRESENTATION

I chose the role of the mother in the presentation. With hindsight I see that I took on a position of 'secondary handicap' in that I remained largely silent, as I imagined the client to be (Sinason, 2010). This was both an assumption about how the client might behave in such circumstances, as well as a way of not having to disclose how much talking about her LD upset me. I have found this type of behaviour in NHS team meetings on my LD placement; for example, sensitive staff members often withdraw from conversations around particularly disadvantaged clients.

Within the presentation, we used a reflecting team in much the same way as they might be employed in a systemic family session. I believe that they were tacitly given permission to say what the rest of the group found hard to articulate and thus acted as the group's unconscious. On reflection, this process is true too of my experience of being part of the reflecting team in family therapy with clients with LD. It often fell to us to name the difficult feelings and thoughts that the family brought and were unable to acknowledge.

Looking back, I wish that the presentation had delved deeper into the family's beliefs about how services and systems viewed their having a LD. I have subsequently become interested in how society's views on LD inform clients' beliefs about their own capacity to parent. On placement, I have realised that there exists an almost universal assumption that people with LD are not able to raise their children adequately, and that clients then doubt their own capacity.

Two group members taught us a lot about systemic thinking and guided the presentation format. I was interested in the way in which the other group members responded to the relative expertise of these two members. They felt uncomfortable with feeling ignorant about systemic theory. Sinason (2010) talks about the discomfort clinicians feel in 'not knowing' and I have witnessed how staff, insecure in their roles (particularly as NHS resources shrink) may pretend to know something regarding their clients. In the PBL, I was able to reflect on how it might feel to have to take up this position of 'not knowing'

with a client who is turning to us for expert advice. The presentation also allowed us to talk about our discomfort with 'not knowing' and to apply this to our practice with clients and staff, relating it to the systemic model (Dallos & Steadmon, 2009).

Facilitators and managers

Each PPDG group is allocated a facilitator and the group usually met with her present. However, when she was unavailable, we did not meet. This could further be understood in psychodynamic terms. There might have been an element of dependency on her to hold the difficult thoughts and feelings for the group (Bion, 1967) as we struggled to come to terms with the PBL.

The way in which we treated our facilitator can be understood in a Kleinian sense (De Board, 1997). I think we are an anxious group, seeking a leader who would relieve us of this. Initially I think we believed that our facilitator was omnipotent, spending much time talking about her positive qualities. When we realised that she is flawed (she did not come to some of our meetings nor to our presentation) we began to denigrate and even split. One member brought up how this process may have interfered with the PBL task. Though I have not witnessed this process in my current NHS placement, this somewhat paranoid schizoid position was evident in the way that a headmistress was treated by her staff in a school where I used to teach. While some adored her and were unwilling to see any faults, others disagreed, viewing her as vindictive and unpredictable. This regressive state placed teachers at loggerheads over educational decisions and threatened the learning atmosphere for students. It

is easy to translate this to the way in which staff disharmony can be experienced indirectly by clients, and how it can affect the quality of service provision.

Other learning

Through my experience of the PBL task, I have had a number of realisations that I have brought to bear in NHS teams. I have seen for example that systemic skills are not just suitable for family therapy, but can be helpful in team meetings, allowing people to develop formulations through circular questioning. I was able to reflect how this method became the way in which we both addressed the PBL task and conducted the presentation, asking questions of each other to elicit the patterns and processes that the family in the case study found themselves entwined in.

I noticed that the PBL task fostered trusting relationships, developed collaboration over competition, and allowed us to share responsibility for the workload. We realised that while the end product is important, the process of learning is equally of value. This resulted in a more equitable process and presentation than the one delivered last year. I was particularly interested in seeing that similarly, one residential home for people with LD tended to collaborate so as to establish the best possible environment for the client. Each staff member is valued and time is taken to implement suggestions. This has measurable benefits for the client. Within both the NHS and our PPDG group, I have seen the advantages of an egalitarian work ethic.

There is also a parallel between how the PBL allowed the group to learn to hold the unconscious emotions of trainees, and how we are learning to withstand the powerful feelings that clients evoke in us (De Board, 1997). I have noticed how similar unconscious processes operate in MDM (multi-disciplinary meetings) within the NHS and within staff teams in care homes, particularly where change is imminent. I see also how negative emotions regarding LD affected the group's ability to think and process the PBL task (Lemma, 2006), and how a similar process is sometimes at work within LD team meetings, clouding professionals' judgments.

I have noticed that in a comparable way to how we approached the task, MDMs and case discussion groups are facilitated through prioritising equity, listening and reflecting. This allowed me to become more attuned to the ways in which supervision and consultation mirror these therapeutic skills and how they benefit from being similarly conducted. Non-directive supervision has also made me aware of how consultation plays an important role in providing staff with a flexible space to think about clients (DoH, 1997) and how this mirrors the reflective way that we approached the PBL task. I was further able to apply this learning to consultation with staff at a care-home, facilitating rather than leading discussions.

The fact that all professionals mentioned in the PBL task were anxious suggests to me that staff anxiety may reflect the transference of clients' unconscious feelings of insecurity and experiences of powerlessness (De Board, 1997). I have become aware of the vulnerability of the LD client group,

and have noticed that the way in which staff perceive the client group characterises how they then work with them. The PBL task showed us, through both content and the process we went through to understand it, some of the intricacies of the relationship between staff, the NHS and clients.

CONCLUSION

The PBL task was difficult emotionally. It forced me to confront my biases about people with disabilities. The PBL process and presentation served the function of containing this. Clients, NHS staff and care-workers also need a secure community into which to project anxieties (Hinshelwood, 1990). I think this is what the LD service offers, serving a function for staff, families and clients not unlike that of a mother for her child (Winnicott, 1962). Similarly, the way that the PBL provided a space for us to understand and digest our feelings about LD in a sensitive and digestible way provided us with safety (Hinshelwood, 1990). Since society has failed to contain the pain experienced by people with LD (Sinason, 2010), such containing interventions from services are also imperative. The genuine empathy I have witnessed in staff may allow clients to re-evaluate and manage their internal states. I believe that the PBL task served a similar function for us as developing trainees, holding and transforming our anxiety and allowing us to learn in a contained space.

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Summary: Personal and Professional Learning Discussion Group

Process account

Year 1

September 2010

Word count: 243

Eight first year clinical psychologist trainees met once every month for a year in a Personal and Professional Development (PPD) group to discuss issues related to training. Each trainee had a characteristic way of dealing with the insecurities elicited by their new and challenging role, and this was understood in the context of how individuals relate in therapeutic groups within the NHS. As time passed, the group moved from task interactions, based on the PPD presentation and agenda setting, to relationship interactions, where the wellbeing of members became primary (Forsyth, 2006). This included a checking-in and checking-out system where individual members were given an opportunity to share. This allowed for more intimacy and positive risk-taking in sharing personal genogram histories, as well as in presenting clients' formulations. The group learnt more about psychodynamic group facilitation from the open and unstructured style of the facilitator, a member of the course team. Discussion often centred around Psychodynamic and Cognitive Behavioural Therapy understandings of clients' difficulties, while attempting to incorporate these into a holistic view of the client. A video-taped discussion about trauma proved useful in challenging entrenched personal and group behaviours and encouraged self-reflection. Typical (unconscious) group behaviours were observed within contexts within NHS work settings, including multi-disciplinary team meetings and care plan assessments. Learning included a better understanding of unconscious group processes, observing a tendency to use the facilitator as a safe base (Bowlby, 1977), as well as identifying typical defense mechanisms (Lemma, 2003).

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Summary:

Personal and Professional Learning Discussion Group Process

Account:

July 2011

Year 2

Word count: 250

A group of eight second year clinical psychology trainees met irregularly over the course of a year in a PPD (Personal and Professional Discussion) group. Though the group covered some academic papers and was engaged in regular discussions around professional development, we felt that it avoided discussions around personal development. At the start of the second year this may have been due to defenses against difficult feelings about the task given to us as an introduction to the second year, however the ongoing use of defenses necessitated other explanations. The use of a rigid structure of checking-in into group sessions might be another form of avoidance. We wondered whether the group may be finding disclosing personal vulnerabilities around experiences on placement and with clients difficult to process.

Menzies-Lyth's (1960) paper provided us with some insight into the role of anxiety in trainees dealing with distress in clients and families and showed how retreating from those anxieties serves a protective purpose. We realised that the development of a group that provides a secure base for its members (Bowlby, 1988), one where exploration and growth is possible, takes time. At the end of the year the group had made some headway in understanding itself and its members as clinical psychologists, but remains somewhat less actualised in exploring personal feelings as reactions to clinical work. We hope to work towards this in our third year.

CLINICAL SECTION

Overview of Clinical Experience over the Five Placements

July 2012

Year 3

Adult Mental Health

This placement was split between a specialist psychological therapies service and a community mental health team (CMHT). The work consisted largely of psychodynamic psychotherapy with a range of clients with severe and enduring mental health needs ranging in age from 20s to 60s. It took place at the CMHT, in client's homes and within an in-patient setting. Presenting issues included PTSD, dissociation, depression, bi-polar affective disorder, psychosis, as well as personality disorder. The placement also involved CBT work within a specialist service for clients with recurrent depression and moderate to severe OCD. I completed several neuropsychological assessments, including one with a man with a colloid cyst and one with a woman with a learning disability. The placement also included co-facilitation of a weekly mindfulness group for people with depression, working alongside a counseling psychologist. Following budget concerns at Trust level, I completed a qualitative thematic analysis survey of service users satisfaction with a dialectical behavioural service (DBT). This involved in-depth interviews of six clients, as well as research into the nature of DBT and whether it was meeting Trust and service-users requirements. Results allowed for continued Trust funding and were disseminated at Trust-wide psychology level. Together with another trainee, I designed and delivered a two-session Introduction to Mindfulness program to a group of service users within a mental health charity setting.

People with Learning Disabilities

This placement was based with a community team for people with learning disabilities (CTPLD). As part of a multi-disciplinary team (MDT), I was involved in work with people with mild to severe learning difficulties with a variety of functional presentations including depression and anxiety. This included work with speech and language therapists, nurses, social workers, psychiatrists and occupational therapists. I worked closely with clients with Asperger's, autism and Down syndrome. I conducted various psychometric assessments, including one for dementia with a woman with Down syndrome and another to determine cognitive functioning and capacity for independent living with a woman with autism. I was also involved in conducting neuropsychological assessments of a young man with moderate learning disabilities as well as diabetes and advised care staff about how best to support his health needs. The placement involved work within residential and day centres and service-users' homes. I assisted a psychiatrist in designing treatment for a man with severe dementia. I was involved in assessing a young man with challenging behavior and worked alongside staff and carers to facilitate an improvement in his day-to-day circumstances. I was involved in delivering an eight-week CBT and psycho-education group for people with moderate learning disabilities experiencing anxiety and depression. This involved the adaptation of existing assessment measures, as well as teaching and intervention techniques to meet the specific needs of each individual group member. The group offered an opportunity for psychodynamic group learning. I was also able to take part in family therapy as a member of the reflecting team. I consulted to a care home on the management of a woman with Down syndrome and possible dementia. This involved discussion and psycho-education of staff and family.

Child and Adolescent

This placement was split between two child and adolescent mental health teams (CAMHS). This allowed for a wider range of client experience, and an opportunity to be supervised in CBT as well as in systemic, psychodynamic and integrative therapies. The placement involved seeing clients aged 6 to 17 with a variety of presenting issues including depression, anxiety, autism, self-harm, eating disorders, and ADHD. Interventions lasted from one session up to 12 weeks. I worked alongside the psychiatrist in assessing clients for autism and within a MDT in the treatment of each individual young person. I was also part of the family therapy team, regularly taking an active role as part of the reflecting team. I worked closely with families, teachers and other professionals. I conducted various neuropsychological assessments, including working with a boy with behavioural concerns and autistic traits. For the LAC (Looked after children) team, I assessed a girl with a complex and abusive background and learning disabilities for autism and was involved in advising about her schooling placement and in consultation to her foster mother. I was also involved in working with a family therapist in a joint intervention with a young person with school refusal. I had experience of working with a young man with Proteus syndrome. The placement also involved attendance at psychodynamic case discussion groups. I attended a two-day schema therapy workshop as well as an infant observation course. I designed and delivered a presentation to parents about explaining a diagnosis of autism to their child. I was involved in assisting the consultant psychiatrist in an audit of local autism provision, interviewing various psychiatrists and psychologists so as to inform local practice. I was involved in consultation to various members of the MDT, including primary mental health workers and GP trainees. I designed and disseminated a pamphlet for use within CAMHS by parents in facilitating sleep in their children.

Older Adults

Based primarily within an acute in-patient dementia unit, this placement involved furthering person-centred therapy and service delivery with staff teams and with clients with moderate to severe dementias (including Korsakoff's syndrome, Picks disease, semantic dementia, fronto-temporal dementia, Alzheimer's disease and mixed presentations). Clients ranged in age from late-40s to early 90s. Work involved close collaboration with psychiatrists, occupational therapists, and nurses in the assessment, intervention and management of in-patient and community care. The placement also involved CBT therapy for depression, anxiety and low self-esteem with a community client. I was closely involved in aiding the transition of a 91-year old client from an in-patient dementia unit to a residential home. This involved consultation with staff and family as well as observational assessment of the client and use of the NPI-NH with nursing staff. I was also involved in delivering various formal and informal therapies to clients on the in-patient ward. I conducted various neuropsychological assessments, including assessment for semantic dementia of a 50-year old man with expressive and receptive language difficulties. I was instrumental in the differential diagnosis assessment of a 69-year old woman on an inpatient geriatric psychiatric unit with possible fronto-temporal dementia, using a battery of memory and executive functioning tests. I attended various

specialist conferences including one on learning disabilities and dementia and also the 3-day 27th International Alzheimers' Conference. I also attended a 5-day Level One Narrative Therapy Training Course under the auspices of The Institute of Narrative Therapy, guaranteeing a Level One qualification in narrative therapy. I participated in designing a hearing voices group. I researched the use of non-pharmacological interventions for psychological and behavioural symptoms of dementia for Trust purposes. I facilitated some of a reflective practitioner group with staff within a long-stay dementia inpatient unit. I presented on depression and anxiety in older adults to members of Age Concern. I was also instrumental in researching and devising a comprehensive presentation on the understanding and management of sexual disinhibition in dementia and cognitive impairment. This was disseminated to psychologists for use in teaching. I was involved in consultation to a residential staff team on the management of a woman with challenging behavior and a diagnosis of Alzheimer's disease.. I wrote a book review for The International Journal of Positive Behaviour Support, due to be published in 2012.

Neuropsychology

This placement was based within three hospital settings, one acute, one post-acute and one community, and involved contact with rehabilitation units, neurologists, GPs, an in-patient psychiatric unit, and other community hospitals. Two days a week were spent assessing community clients in all areas of neuropsychology, including traumatic brain injury, post-stroke, post transient ischemic attacks, various dementias, alcohol related cognitive problems, functional cognitive concerns, brain hemorrhage, and other questions of cognitive difficulties, as well as the impact of mood and trauma on cognition and memory. Assessment tools included (but were not limited to) the WAIS-III, WMS-III, WAIS-IV, WMS-IV, TOMM, BMIPB, Hayling and Brixton, Trail Making Test, DKEFS and ToPF. Interventions included advising on behaviour, mood and cognitive strategies, as well as referrals onto other NHS and non-statutory bodies. Within an acute neurology stroke department involved assessment and consultation to an MDT using the BASDEC, HADS and the DISCs, as well as cognitive assessments such as the MOCA and the Addenbrooks. The remainder of the placement involved assessment and consultation within a post-acute stroke setting where assessment and MDT and family consultation was combined with behaviour management strategies. Both the acute and post-acute work was conducted in close collaboration with SALTs, OT, physiotherapists, nursing staff and doctors, including neurologists. Work included consultation to an MDT team within a neuro-rehabilitation unit on the management of a man with a right-sided MCA, as well as a craniotomy, dysphasia and hemiplegia. This client had been followed up from admittance into acute services to rehabilitation stage. I was also involved in assessing and consulting on an inpatient psychiatric client with long-term anorexia and depression, who had been administered ECT and was experiencing memory difficulties. Memory assessments and clinical interview led me to consult to her psychiatrist on various strategies for the management of her transfer to independent living. I delivered a psycho-education presentation on mood management post-MCA to a community non-profit stroke club for people recovering from stroke and their carers.

Summary Adult Mental Health Case Report

**Cognitive-Behaviour Therapy with a woman in her early twenties
presenting with obsessive - compulsive disorder**

Year 1

Word Count: 249

A single woman in her early twenties was referred to psychological services suffering generalized anxiety and panic attacks. Following assessment, using the BDI-II, BAI and Y-BOCs, it was ascertained that she experienced mild depression, moderate anxiety and moderate OCD symptomatology related to various trigger events involving fire. Formulation thus centred around OCD as the presenting problem, anxiety and panic attacks as symptoms of the disorder.

Her obsessions involved injurious intrusive thoughts, doubts and fears regarding her responsibility in causing a fire at home. This resulted in marked subjective distress, leading to ritualistic checking behaviours (including electrical switches and appliances) and some avoidance behaviours, as well as reassurance seeking behaviours. This gives short-term anxiety alleviation. The compulsions take up less than an hour a day. Ms White demonstrated a marked bias in her thoughts regarding responsibility, believing that she would be wholly responsible for herself and others should a fire break out. She also demonstrated this cognitive misinterpretation in other areas of her life, including work. She showed some perfectionist tendencies, a common cognitive bias in sufferers of OCD. Ms White was deemed to be of low risk of self-harm and demonstrated no suicide ideation or intent, despite past self-harming. She was aware of some of the early experiences that have contributed to her beliefs about responsibility and her anxiety. Ms White was very receptive to the CBT model, easily making links between overestimation of the importance of her thoughts and the impact of these on her compulsive behaviours.

Summary Adult Mental Health Case Report

**A neuropsychological assessment of a young woman presenting with
' memory problems'**

Year 1

Word count: 247

A young woman, turning 30, was referred by a consultant neurologist for memory tests following two operations for the removal of colloid cysts in the third ventricle. Concern centred around changes in functioning at work, as well as some changes in behaviour. Previous research has suggested that when removing cysts from this particular part of the brain, accidental damage to the fornices of Monro results in memory impairments (e.g. Aggleton & Saunders, 1997). The woman was seen by a trainee clinical psychologist and a consultant psychologist at a specialist psychology service. Following an in-depth interview into her perceptions of changes in cognitive functioning, her family, educational and work background, as well as her medical history, psychometric tests were administered over six sessions. The WTAR predicted that her pre-morbid Verbal IQ was 86. Using the WAIS-III, a significant difference between Verbal IQ (90) and Performance IQ (74) scores was however found, suggesting that analysis should not focus solely on her FSIQ score (80). Her Performance IQ was lower than expected and was particularly affected by scores in the Digit-Symbol Coding and Symbol Search tasks. Using the WMS-III, no memory deficits were found with scores on Verbal Paired Associates Recall and Visual Reproduction Recall being above average. It was concluded that the young woman had however suffered a brain impairment as evidenced by slowed psycho-motor and processing speed. This is supported by some literature (e.g. Bublak *et al.*, 2005) and would account for the changes in cognitive functioning reported.

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Summary Learning Disabilities Case Report

**An extended assessment of a woman with Down's syndrome who was
referred for possible dementia**

September 2011

Year 2

Word Count: 248

A 48-year old woman with Down's syndrome was referred for a follow-up dementia assessment. Results of the baseline assessment were compared on re-administration of the ABS, DMR and NAID. These showed some change, but not sufficient to suggest a cognitive decline. Therefore no evidence for a dementia process was found, despite the presenting problem of distress, changes in social relating, uncharacteristic verbal aggression, using a chair to manoeuvre around, and an inability to cross thresholds. An extended assessment using the adapted HADS and the BAI showed that she was suffering from moderate anxiety. Adapted CBT assessments for anxiety supported this, as did interviews with staff, family, and psychiatric notes. The client also explained that she was frightened by noises inside and outside of the home. All interviewees reported changes in social, emotional and functional behaviour in the previous two years, but agreed that these had improved recently. The client had begun to move outside of the home and was showing more confidence and less anxiety. She reported feeling better and reassessment on the HADS showed that her anxiety had dropped to within the normal range. I used a functional assessment to explain the disparate presenting behaviours. I discussed various recommendations with staff and delivered psycho-education on dementia and anxiety.

URN: 6106762

An extended assessment of a woman with DS who was referred for possible

dementia

Summary Oral Case Presentation

**From teacher to psychologist: working with a
9 -year old girl with separation anxiety**

October 2011

Year 3

Word count: 499

**This oral presentation uses a case report as an exemplar of my personal
development as a Clinical Psychologist.**

Sarah, a 9-year old girl, was referred to the Psychology Department of the Child and Adolescent Mental Health Service (CAMHS) by her GP. Sarah's parents were concerned about her distress on separation. The GP cited separation anxiety and OCD symptoms, giving some examples of the extent to which Sarah would go so as to be near her parents, for example, crying when her mother leaves her to pay for petrol.

With a background in teaching of about 10 years, I came to Clinical Psychology with experience of working with children of different ages. As a result I had experience of adapting abstract concepts for different audiences. This ability to make learning interesting and applicable came in useful when I was faced with explaining Cognitive Behavioural Therapy (CBT) and the biological and psychological mechanisms involved in anxiety to Sarah. I was also able to apply my teaching skills to engage Sarah in the therapeutic alliance. This was particularly important when thinking about her difficulties with attachment (Holmes, 2001).

Furthermore I found that the creativity skills I developed while teaching were useful in crafting CBT materials designed specifically for Sarah. Sarah loves dinosaurs. We used the analogy of the dinosaur to represent the power of thought in Sarah's symptoms, and she and her parents were able to incorporate the analogy into their everyday life. This helped Sarah recognise when she was engaging in unhelpful thinking.

Sarah's OCD symptoms suggested a structured CBT intervention. It was useful to think with her parents about Sarah's attachment history and to locate attachment within the formulation (Holmes, 2001). The intervention involved psycho-education about the CBT model and anxiety, relaxation strategies, distraction and visualisation skills and the design of a graded exposure hierarchy. Sessions were conducted with Sarah's parents acting as co-therapists (Stallard, 2009). They were able to help her to generalise skills outside of therapy.

Coming from a teaching background also has its challenges. While I had experience of teaching classes of over 30 children, I was accustomed to smaller A-level groups or one-to-one tuition in a Pupil Referral Unit, an adolescent in-patient unit and in private tuition. My therapy experience was also largely with individual clients. I thus found engaging both parents and Sarah a challenge to my ability to keep differing needs in mind. Though there is mixed evidence for the efficacy of involving parents in CBT for anxiety (Creswell, 2010), since the family environment changes over time in response to changes of individual members, it made sense to include Sarah's family in her intervention (Radohl, 2010). This felt particularly important given the relational nature of her presenting difficulty.

In critiquing my intervention, I realised that my alliance with parents may have impacted on my ability to think about seeing Sarah separately. For example, in future I would consider using experiments where the client might practice in-situ separation from her parents.

Summary Older Adult Case Report

**Indirect work with a staff team concerning a lady with
'behaviours that challenge'
in a residential nursing home**

May 2012

Year Three

Word count: 248

Mary, an elderly woman with a diagnosis of mild to moderate dementia of mixed pathology, was transferred to a residential nursing home (RNH) after an extended stay in an acute dementia inpatient ward. She had been living with her daughter since the death of her husband. A steady decline in cognition and mood had meant that she had been seen a number of times by the dementia crisis team. Changes in personality and orientation had been defined as behavioural and psychological symptoms of dementia (BPSD) (James, 2011) and her daughter was finding it increasingly difficult to manage these without professional assistance.

Following her transfer to the RNH, I became involved in assessing how best to support staff in helping Mary settle into her new home. Assessment included the neuropsychiatric inventory nursing home version (NPI-NH), showing that Mary experienced high levels of agitation, was often disinhibited in what she might say and do, and demonstrated the high level of care required from staff. This resulted in psycho-education around person centred care for dementia (Kitwood, 1997) and the unmet needs in dementia model (Cohen-Mansfield, 2000), as well as formulation around attachment theory (Bowlby, 1988). This was delivered week-by-week, as suggested by the successful work with similar clients within the Newcastle Challenging Behaviour Team (James, 2011). Readministration of the NPI-NH showed a significant decrease in the severity of many of the BPSD. Staff felt supported and empowered by psychological input and were somewhat more motivated to implement PCC in their work.

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RESEARCH SECTION

Service Related Research Project

**Service-users experiences of the process and outcome of a DBT
service: a service evaluation**

June 2010

Year 1

Word count: 2,999

Word count abstract: 216 words

(total word count including appendices 7,995)

*All identifying characteristics, including names and places have been changed
to ensure anonymity*

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ABSTRACT

Dialectical behaviour therapy (DBT) was developed to improve the lives of those with a diagnosis of borderline personality disorder by teaching them skills to manage emotions and relationships through the integration of Cognitive Behaviour Therapy and acceptance based therapies (Linehan, 1993). This study used the six stages of semantic thematic analysis (Braun & Clarke, 2006) to analyse the experience of the process and outcome of a DBT service of six service-users. Participants were at various stages of the 18 month DBT service, providing valuable process information. Semi-structured interviews were transcribed and analysed. Five super-ordinate themes were identified: *Positive Experiences*, *Things I struggled with*, *What DBT has taught me*, *What I'd like to see after DBT* and *Improvements*. *Positive Experiences* was further differentiated into a number of sub-themes given the overwhelming positive response to the service. Mindfulness proved a particularly useful skill in facilitating the learning of other skills. Distress Tolerance and Emotion Regulation were deemed very useful, but difficult to learn and to maintain when distressed. Some anecdotal evidence for a reduction in self-harming behaviour, as well as in-patient admissions and visits to A and E, was found as well as a reported increase in emotional regulation and interpersonal relationship effectiveness. Improvements to the service, as well as limitations to the study, are discussed.

ACKNOWLEDGEMENTS

I would like to thank my university supervisor, as well as the supervisor in the service, my clinical supervisor and particularly all participants. Each of these people contributed invaluable to the process of collecting and analysing data.

INTRODUCTION

Linehan (1993a) developed Dialectical Behavioural Therapy (DBT) to promote affect regulation in people with a diagnosis of Borderline Personality Disorder (BPD) (Wisniewski & Ben-Porath, 2005). Four modules are taught in groups (see Appendix 4) with a Mindfulness module between each skill set: Distress Tolerance, designed to help clients tolerate painful emotions, Emotion Regulation, teaching that all emotions are legitimate, and Interpersonal Effectiveness, providing skills for dealing with relationships (Linehan, 1993a). One-to-one therapy and telephone coaching is designed to decrease suicidality as crisis behaviour and foster skills generalization (Linehan, 1993a).

The service

The rolling-group DBT service for people with a diagnosis of BPD comprises weekly group sessions lasting 12 months, and weekly individual sessions, lasting 18 months. It forms part of a large mental health trust and has been running for nearly two years.

Rationale for evaluation

DBT is being implemented in the NHS for the treatment of BPD (Hodgett, Wright & Gough, 2007). It is recommended by the NICE Guidelines (2009) for women with BPD with recurrent self-harm. Previous evaluations of DBT services showing positive effects have been conducted in the UK (Hodgett, Wright & Gough, 2007), US (Linehan, 1993a) and elsewhere.

Characteristically quantitative methods are used to evaluate service provision, however the value of a service also lies in whether it meets the needs of service-users measured qualitatively (Clifford, 1997). Various government bodies (eg. NHS Health Advisory Service, 1997; Department of Health, 1999a, 1999b, 2001b) have focused on the importance of involving service-users in assessing their standards of care. The commissioning trust is thus interested in service-users experience of the DBT service.

Aim

The author of this study, a trainee clinical psychologist, was asked by the lead therapist of a DBT service to evaluate whether levels of self harm had decreased since the service's inception. Looking at Diary Card records (see Appendix 4) kept by service-users proved unreliable, since they were inconsistently and unreliably completed and collected.

In collaboration with the lead therapist, it was decided that the aim of this exploratory study was then to give voice to service-users' experience of a DBT service so as to better identify areas for future research within the

service. The research question was thus framed as: What are service-users experiences of the process and outcome of (this) DBT service?

METHOD

Participants

One male and five female clients with a diagnosis of BPD (DSM-IV-TR, American Psychiatric Association, 2000), who had taken part in the DBT service, were selected via criterion sampling.

Table 1: Participants' Details

	Gender	Age	Medication	Length in DBT Service	Completed Service
Lynn	F	46	300mg Quetiapine 400mg Carbamazepine 225mg Venlafaxine	6 months	no – receiving group and individual therapy
Fiona	F	51	150mg Sertraline	one and a half years	yes
Peter	M	37	50mg Thiamine 45mg Mirtazapine 5mg Olanzapine	one year	no - receiving individual therapy only
Denise	F	43	20 mg Escitalopram 7.5 mg Zopiclone	one and a half years	yes

Eloise	F	28	350mg Quetiapine	one year	no – receiving group and individual therapy
Michelle	F	34	37.5 Venlafaxine 1mg Risperidone	4 months	no - receiving group and individual therapy

Procedure

A semi-structured interview schedule (Appendix 2) was devised in collaboration with the lead DBT therapist addressing practical aspects (Diary Cards, Skills Cards, skills teaching, telephone contact, homework sheets) and the process of service provision (perceptions of group and individual sessions, generalization of skills to daily life) (for a list of DBT skills and services, see Appendix 4).

One- to- one interviews were deemed appropriate given the potential issues of confidentiality and disclosure. All nine users of the service were invited by letter to take part, with the option of a care co-coordinator present (Appendix 1). An interview was arranged at the nearest CMHT for the six service-users who responded positively. None requested a care co-coordinator. Reasons were not provided by those who did not respond. Service-users were provided with full written informed consent (Appendix 3). Interviews lasted between 25 and 40 minutes and were audio recorded and anonymised. Transcriptions were further anonymised, using pseudonyms (see Appendix 5 for an annotated extract).

Analysis

Braun & Clark's (2006) semantic thematic analysis approach was chosen as the evaluation's purpose was to organise participant's experiences. It consisted of six progressive stages of data analysis using an inductive approach to generate data-driven codes (see Appendix 8). Five super-ordinate and further subordinate themes were elicited through analysing transcripts sequentially. To provide external validation, a research tutor reviewed transcripts. Themes were altered accordingly. Data was reviewed again to ascertain that it collated with themes.

Ethics

University and NHS ethics were not required, but participant safety was managed in a number of ways. Service-users anonymity and confidentiality was ensured through encoded portable electronic data devices. In the event of participants becoming distressed as a result of the interview, they were requested to contact their DBT therapist since all therapists were made aware of the interview.

RESULTS

Semantic thematic analysis generated five themes and six sub-themes.

Table 2: Themes and Sub-Themes

Themes	Sub-themes
Positive Experiences	Helpful Skills Mindfulness Homework Experiences of the group One-to-one experiences DBT service Provision
Things I struggled with	
What DBT has taught me	
What I'd like to see after DBT	
Improvements	

1. Positive Experiences

Given that all participants identified the DBT service experience as a positive one, this theme was further analysed into subordinate themes:

Helpful skills.

All participants named Emotion Regulation and Distress Tolerance skills as the most helpful when distressed, providing the greatest relief and alternative coping strategies.

'Emotion Regulation is good... emotions rule my life ... actually seeing emotions as they are, for a reason, I've never thought that before' (Lynn, line 644).

These sets of skill were however the most difficult to learn and implement since they were skills participants had little experience of. A lack of these skills was identified by all participants, both implicitly and explicitly, as characterising BPD.

Self-soothing was mentioned by all but the newest member as helpful when moderately distressed:

'My worry is that I'm going to be violent to someone. Self-soothing with music helps' (Peter, line 101).

Mastery, part of Emotion Regulation, was also frequently mentioned as doing 'a lot towards making a life worth living' (Eloise, line 1114). Most participants acknowledged that shame about behaviours had characterized their lives prior to DBT, and that being efficacious through skill usage contributed to a more competent sense of self.

Mindfulness.

Mindfulness was credited by all service-users for its effectiveness in teaching the skill of reflecting on thoughts and affect so as to distance from emotional intensity, often for the first time in their lives.

'If I can live in the moment.... It's much easier to control your life... blanking my mind helps. I'm able to get rid of intrusive thoughts' (Peter, line 9).

Being able to acknowledge 'but not stay with emotions', just 'push [emotion] away' (Denise, line 290), was especially useful to service-users, including those newest to the service. Mindfulness provided a 'wind-down' at the end of emotionally-charged group sessions. This is supported by Linehan (1993a). Despite it being uncomfortable to sit with emotion, mindfulness was very useful in de-catastrophising service-users experiences and regulating emotion:

'It stops you rolling off into a panic, because you stop and think what's that thought? ... Before... the emotion has just rolled ... I've ended up psychotic. ... I've prevented [hospital] five times by using Mindfulness skills' (Lynn, line 641).

Homework.

Overwhelmingly the sense of mastery that the Skills Diary Cards gave all clients, having to consciously revisit skills on a daily basis, was helpful:

'To sit down and see what's happened during the day ...and think I used this skill for that... reinforces it for me, that's such a good thing' (Lynn, line 689).

All clients recognised that repeating skills learnt in the group through doing homework was valuable in keeping skills 'in your mind all the time' (Eloise, line 1553). Skills Diary Cards and Diary Cards were however sometimes described as labour intensive, confusing and emotional. This made homework difficult to complete, but clients felt under pressure to do so, so as to avoid being singled out in the group.

Experiences of the group.

Newer members were understandably anxious, but found older group members very supportive. Older members valued friendships that had developed through shared experiences of the group, continuing after they had left the service. Reciprocity and support, as 'everyone's in the same situation' (Fiona, line 212), was valued.

'[U]sing experiences from other people ... Their examples I thought were helpful, how they cope and what they use' (Denise, line 424).

Responses suggested that by helping others deal with their problems, service-users were able to understand their own difficulties in a less threatening manner.

One-to-one experiences.

One-to-one therapy was highly valued by all service-users, particularly for its usefulness in clarifying and applying skills learned in the group, but in a safer, more intimate environment.

'So if anything is troubling you, that you are struggling with, you get help, it's a back up' (Lynn, line 702).

Therapists' honesty, availability, consistency, commitment and pragmatism were particularly valued. Going through homework with therapists was also mentioned as helpful in suggesting alternative skills.

DBT service provision.

Lynn's accolade reflected the overwhelming positive response to the service: 'If I won the lottery, I'd set one up myself' (line 809). There was differing opinion regarding the DBT telephone service. While three service-users felt that when distressed they tended to withdraw from social contact and thus the telephone was superfluous, others made effective use of it in times of distress. Being able to phone/ text for advice on skills when they felt particularly unhappy was valued.

'Sometimes when ...you're feeling really bad, just to know that you can pick the phone up ... and talk through the skills ... to maybe stop self-harming' (Fiona, line 184).

2. Things I struggled with

Overwhelmingly, responses to both the skills and service in general were very positive. However, given problems with affect regulation, the difficulty of

learning Emotion Regulation was frequently mentioned. Radical Acceptance was another difficult skill to master, since it differed from past CBT strategies. Newer members also struggled with being non-judgmental, with self-soothing, and patience, all skills traditionally not characteristic of those with a BPD diagnosis (Linehan, 1993).

Four participants mentioned that they found the disclosure and level of expectation placed upon them by virtue of being in the group sometimes unhelpful. Though Linehan (1993a) favours open groups, some service-users mentioned they felt disrupted by members and therapists joining and leaving.

Despite overall positive responses regarding the usefulness of skills, they sometimes failed to generalize when managing acute distress. This was viewed as very disappointing by some clients:

'when I'm quite sad, a lot of the skills don't seem as useable as if I'm doing a lot better' (Eloise, line 1058).

While clients can sometimes reach for the telephone or Laminated Cards, old maladaptive self-harming coping strategies still intervene.

3. What DBT has taught me

'I do think [DBT] has changed me... it's helped me ask for more help and actually say how I feel' (Denise, line 533).

The paucity of space available here cannot adequately cover the breadth nor depth of clients' positive learning experiences. 'I'm totally different... I have done amazingly' said Fiona (line 1635). To varying degrees, all service-users feel empowered by a new sense of control over their emotions, in part due to the effectiveness of Emotion Regulation and Interpersonal Relationship skills. Self – blaming had measurably decreased, 'now I hardly ever beat myself up about things, '(Peter, line 8) and self- efficacy increased. There is a perception that the way in which skills are taught, makes them seem 'realistic, achievable...easy to follow' (Peter, line 40).

Through a combination of the therapeutic relationship, the group experience and focusing on skills teaching, clients' automatic emotional thinking has altered, sometimes even in the most distressing of situations:

'...if I want to cut myself, now I'd say: This is how I feel' (Denise, line 30).

'Rather than automatically jumping to self-harm' (Eloise, line 1080), DBT skills have provided alternative behavioural and affect responses, such that self-harming has either lessened or been eradicated in all clients.

'The skills have certainly helped me to self-harm less ...I've [self harmed] a few times over the last year whereas it used to be every week... maybe every day, I guess it's quite a stark change' (Eloise, line 1064).

DBT has also improved clients' relationships with partners and parents by developing communication skills and increasing the individual's ability to identify and express needs effectively:

'DBT has helped me ask for more help and say how I feel' (Michelle, line 536).

DBT is helping clients to be kinder and less judgmental of themselves, thus improving their quality of life.

4. What I'd like to see after DBT

'...you really need to reinforce things and not get into old habits and support each other... I feel kind of isolated and it's all just kind of over' (Denise, line 495).

All clients supported the idea of a structured 'after- DBT' service, most ardently by those who had completed the 18 - month program. Clients only receiving one-to-one therapy also felt that since they no longer received group skills training, they were

'not brushing up on [their] skills...After you've left the group, it's very easy to, not forget your skills, but they sort of slip into the background and you need to be reminded' (Fiona, line 1566).

An infrequent group format was favoured, focusing on reminding clients about the variety and use of skills when faced with challenging and emotional circumstances. Facilitated by a DBT therapist, the group's purpose would be to reinforce adaptive behaviours learnt and discourage recourse to habitual responses.

5. Improvements

Although all service-users were positive about their experience, all mentioned improvements. Overwhelmingly clients would thus appreciate a less regular group after the official end to the service so as to provide for revising skills. It was suggested that the extra-curricular support this group would provide could alternatively be facilitated through a self-help website specifically for users of the service, or through podcasts.

Most clients felt that the variety of skills to be learnt was not facilitated by the hurried nature in which they were sometimes explained, or the 'complicated use of acronyms' (Michelle, line 602) on the Skills Diary sheets. Both teaching and layout could be improved.

'Because when I was first taught mindfulness, I thought this is the main crux of [DBT]' (Eloise, line 1200)

Given the rolling nature of the group, the provision of a framework and overview of skills would help to situate a myriad of new skills in clients' minds.

As discussed above, mindfulness proved useful to all participants. Clients felt that it was imperative that at the end of every group session, facilitators use mindfulness as 'time-out', as sessions sometimes raised distressing emotions.

Since at times, skills do fail, therapists and clients could co-create an individualised plan for acute events. This could have a list of skills to try out in a particular order so as to manage extreme emotions, because 'it's a bit much to take in when upset' (Eloise, line 1427).

DISCUSSION

The study aimed at investigating service-users experience of a DBT service and whether it had proved useful to them. DBT goals are reducing suicidality, providing some control over behaviours, and an increase in basic life coping skills (Dobbin, 2006). At least some of these outcomes were achieved by each service-user in this study, suggesting that an effective service is being provided, and indeed one that is better than anything previously offered to them. Even those service-users who were newer to the service are better able to regulate emotion and are aware of the beneficial impact of this change on their immediate social environment. Responses focused on increased emotional control and interpersonal effectiveness, as well as decreased impulsivity (Linehan, 1993b), although the extent to which this was true differed markedly across participants. This was not necessarily a reflection of how long service-users had spent in the service.

As found by Barley *et al.*, (1993), clients felt that the positive effects of being part of the DBT service were at least in part due to the quality of non-judgmental, available relationships with therapists and other group members. Despite some criticism of techniques and tools, an overarching positive response to the level and type of service provision was found.

Overwhelmingly, the process of learning new skills has proved useful, although their effectiveness and availability in times of acute distress were sometimes deemed disappointing. There is some remaining evidence of polars of thought, affect and behaviour, characteristic of BPD (Dobbin, 2006). Some self-harming behaviour continues. This may be related to the difficulty in learning, accepting and maintaining Emotion Regulation and Distress Tolerance.

Service feedback is bullet pointed in Appendix 7, and plans have been made to feedback to the service in July 2010.

LIMITATIONS

Since some service-users did not accept the invitation to take part in the study, responses may not adequately represent the experiences of all service-users of this particular service. Given that those with a diagnosis of BPD are difficult to engage (Waldinger & Gunderson, 1984), some clients may have found it problematic to commit to taking part.

Only two of the participants had completed the service, while the rest were at differing stages of therapy. Experiences of the service therefore differed, and it was sometimes difficult for the researcher to analyse responses in a meaningful way. Furthermore, since some transcripts generated richer data than others, quotes may be slanted towards some participants' views, however an attempt was made through credibility checks to alleviate this limitation from theme generation (for further reflections, see Appendix 6).

Because of concerns about participant safety, it was not feasible to ask questions that might generate significant distress. Results reflect spontaneous responses to potentially less invasive questions and thus rely on participants' disclosure. Future evaluations could focus on how to better support clients learning Distress Tolerance and Emotion Regulation, and any correlations with self-harming behaviours.

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Appendix 1

DBT Invitation Letter

Dear DBT service-user

My name is XXX and I am a trainee clinical psychologist at the University of Surrey. As part of my course I have been asked to evaluate the DBT service that you have been a part of. The reason for this is that your therapists, as well as the Trust, want to make the service the best it can be so that future DBT service-users can benefit.

The reason I am writing this letter is to ask whether you would agree for me to interview you on your experiences of the DBT service. You are welcome to have someone there with you – perhaps a friend or your Care Co-ordinator. The questions will be around how useful you thought the service was to you and what improvements you think could be made. It should last no longer than an hour and will take place at your nearest CMHT at a time that is convenient for you.

Please feel free to contact me at YYYY CMHT on the above number should you have any queries. I do hope that we have an opportunity to meet soon to discuss the DBT service.

Sincerely

XXX

Trainee Clinical Psychologist
Psychologist

ZZZ

Consultant Clinical

Appendix 2

Interview Schedule

Interview Schedule

Thank you for agreeing to see me today and for taking part in the study. Here I have a letter telling you a little more about the study (hand letter and let them read it). Do you have any questions about the letter?

As you know I am going to talk to you about your experiences of the DBT group and the skills you learned. You can withdraw from the interview or study at any time without giving me a reason. As you know, the interview and write up is anonymous, your name won't appear anywhere on the report. The report will be seen by my university supervisors and by ZZZ. I will give a short report to the therapists on the findings, but your words will remain anonymous, so they won't know who said what. Does that make you feel more comfortable? Good. If you are ready we can start the interview.

N.B Prompt questions can be used depending on the participants' responses to the questions to help elicit answers.

Introduction

1. How do you feel about being part of the DBT service?

Prompt did you enjoy it? not?

Were the skills useful? Not?

Understanding the techniques used

2. Did you find any of the skills you learnt in the group more useful than others? If so, which ones?

Prompt: Mindfulness, Interpersonal Effectiveness, Emotion Regulation and Distress Tolerance

Usefulness of how techniques are embedded

3. *How useful did you find the handouts that were given to you at each group session?*

Prompt: did they help you to remember/ practice the skills?

4. *How useful did you find the homework sheets?*

Prompt: skills diary cards

5. *Do you have any ideas about how the homework sheets or handouts can be improved to make them easier to do and understand?*

*Prompt: shorter/longer
Coloured paper*

6. *Are the laminated prompt cards useful?*

Prompt: Do they help remind you?

7. *How useful is the DBT telephone line?*

Prompt Have you used it? Was it useful?

Usefulness of skills

8. Are there circumstances that you find it difficult to put the DBT skills into practice?

Prompt is it because the skills aren't practiced enough

9. When you are not coming to the group, how easy/ hard do you find it to remember the skills and use them?

Prompt; What do you do to remember the skills?

What makes it easy/ hard to remember them?

10. Do you have ideas about how you can be helped to maintain the skills after the group has finished?

Prompt: Reminders? Texts?

Current wellbeing and effect of DBT on this

11. Would you say that DBT has affected your wellbeing since the group finished/ since you started attending (as appropriate)? If so, how?

Prompt: positively or negatively?

12. Have the skills helped you since the group finished?

Extra question – Not for those who completed the group in the first session

12a. What is your feeling about having a new therapist observing the group?

Prompt Was it helpful? Not?

Final remarks

13. Are there ways that you think the group or individual DBT can be improved?

Prompt: can therapists improve how it is taught?

End of session

Thank you so much for taking part in the interview. I will now listen to the tape recording and make notes on what you have to say. Do you have any questions before we end?

Appendix 3

Informed Consent

I _____ hereby agree to take part in the DBT Service Evaluation conducted by XXX, trainee clinical psychologist at the University of Surrey. I understand that the purpose for the interview is that the DBT service wants to improve the provision it gives to clients. I

understand that the questions will be around how useful I thought the service was and what improvements I think it could make. I have been informed that I can withdraw at any time from the study without giving a reason. This will not affect the treatment I am receiving. I am also allowed to have someone of my choosing in the room with me should it make me more comfortable.

I also understand that my data will be anonymous, that is that my name will not appear on the report and that no-one, other than XXX (and if I chose to have someone else in the room with me) will know that these were my words. The interview will be taped and transcribed and my name will not appear on the recording. In the report, you will give me a pseudonym (a made-up name).

I understand that my data will remain confidential. This means that it will not be shared with anyone outside of the DBT service, those learning from the report at the university, or those involved in reading and marking the university submission.

Signed _____

Date _____

Appendix 4

DBT Skills Summaries

Table 3: Dialectical Behaviour Therapy Skills (based on Linehan, 1993a)

Skill	Core Mindfulness	Interpersonal Effectiveness	Distress Tolerance	Emotion Regulation
Acronym	none	DEAR MAN GIVE FAST	ACCEPTS IMPROVE Self soothe using the 5 SENSES	PLEASE MASTER
Skills	Observe Describe Participate Non-judgmentally One-mindfully Effectively	Describe Express Assert Reinforce Mindful Appear Confident Negotiate Gentle Interested Validate Easy Manner Fair Apologies Stick to Values Truthful	Activities Contributing Comparisons Emotions Pushing Away Thoughts Sensations Imagery Meaning Prayer Relaxation One thing at a time Vacation Encouragement	Physical illness Eating Altering drugs Sleep Exercise
Principle	Balancing emotion and reason	Improve responses to interpersonal situations	Accepting and understanding emotions	Radical Acceptance of emotions and reactions

Table 4: Practical constituent parts of DBT service (based on Linehan, 1993a)

Component	Description
Skills Diary Cards	Handed out each week at group sessions and completed daily. Discussed weekly in the group sessions. Addresses daily use of skills learnt (past and present).
DBT Diary Card	Completed daily and discussed in individual therapy sessions. Tracks use of self harming behaviours (alcohol use, legal and illegal drug use, self-harm) as well as suicidal and self harming ideation. Rating scale.
Laminated Cards	Handed out after skills are taught. Small and are thus easily portable. Summarise skill acronyms for reminding clients about the skills that they have learnt so that they have access to alternative coping strategies when distressed.
DBT telephone service	Clients are given the mobile number of the lead DBT therapist who can be contacted when the client is distressed.
Skills handouts	Given each week and relating to the new skills being covered.
Homework sheets	Completed each week when new skills are taught so as to reinforce learning.
Chaining Cards	Completed in one-to-one therapy to track the process of suicidal or self-harming behaviours.

Dialectical Behavior Therapy DIARY CARD

Name _____

Date started: _____

Date	Alcohol		Over-the-Counter Medications		Prescription Medications		Street/Street Drugs		Suicidal Ideation (0-6)	Mood (0-6)	Self-Harm		Used Skills (0-7)*
	#	Specify	#	Specify	#	Specify	#	Specify			Urge (0-6)	Action Yes/No	
Mon													
Tue													
Wed													
Thu													
Fri													
Sat													
Sun													

- 0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to

- 3 = Tried, but couldn't use them
4 = Tried, could do them but they didn't help
5 = Tried, could use them, helped

- 6 = Didn't try, used them, they didn't help
7 = Didn't try, used them, helped

SKILLS DIARY CARD INSTRUCTIONS: Circle the days you worked on each skill.

1. Wise mind	Mon	Tues	Wed	Thu	Fri	Sat	Sun
2. Observe: just notice	Mon	Tues	Wed	Thu	Fri	Sat	Sun
3. Describe: put words on	Mon	Tues	Wed	Thu	Fri	Sat	Sun
4. Nonjudgmental stance	Mon	Tues	Wed	Thu	Fri	Sat	Sun
5. One-mindfully: in-the-moment	Mon	Tues	Wed	Thu	Fri	Sat	Sun
6. Effectiveness: focus on what works	Mon	Tues	Wed	Thu	Fri	Sat	Sun
7. Objective effectiveness: DEAR MAN	Mon	Tues	Wed	Thu	Fri	Sat	Sun
8. Relationship effectiveness: GIVE	Mon	Tues	Wed	Thu	Fri	Sat	Sun
9. Self-respect effectiveness: FAST	Mon	Tues	Wed	Thu	Fri	Sat	Sun
10. Reduce vulnerability: PLEASE	Mon	Tues	Wed	Thu	Fri	Sat	Sun
11. Build MASTERY	Mon	Tues	Wed	Thu	Fri	Sat	Sun
12. Build positive experiences	Mon	Tues	Wed	Thu	Fri	Sat	Sun
13. Opposite-to-emotion action	Mon	Tues	Wed	Thu	Fri	Sat	Sun
14. Distract	Mon	Tues	Wed	Thu	Fri	Sat	Sun
15. Self-soothe	Mon	Tues	Wed	Thu	Fri	Sat	Sun
16. Improve the moment	Mon	Tues	Wed	Thu	Fri	Sat	Sun
17. Pros and cons	Mon	Tues	Wed	Thu	Fri	Sat	Sun
18. Radical acceptance	Mon	Tues	Wed	Thu	Fri	Sat	Sun

FIGURE 4.1. Front (top) and back (bottom) of a DBT diary card. The entire back half of the card is used in skills training sessions; the front half is used in individual therapy except for the last column ("Used Skills"), which is also employed in skills training.

Appendix 5

Annotated Transcript Extract

Possible themes	Line	Transcript	Initial coding
What DBT has taught me	1044	I: how do you feel about being part of the DBT service?	
	1046	J: Well I definitely feel lucky at having it as an option. Up until	Lucky for given choice.
	1048	now I hadn't really been offered anything structured, till now I	Past choices in
	1050	hadn't really been offered anything structured in the mental	m/h unstructured
	1052	health services and so this is really trying to give you proper	DBT as providing skills
	1054	things, skills to try and that starts to become a lot more in your	Become
	1056	mind, second nature, so you start thinking: what should I be trying	automatic
	1058	to do and at least that in itself is a bit of a distraction, it tries to give	<u>Distraction</u>
Useful skill	1060	you something different to do rather than just going down the	Alternative to past repetitive
	1062	same old worn paths and despairing, you cant really solve	behaviours
	1064	it all, so when I'm really quite	Skills not usable when sad

When skills fail		sad, a lot of the skills don't seem	
	1066	as usable as if I was doing a lot	Hopeful that
	1068	better but at least, hopefully,	some skills will be
	1070	within there because there are	useful when
	1072	quite a lot of skills there is	distressed
	1074	something in there that could	
	1076	have a good effect.	(Probably the)
Impact on self harming	1078	I mean for some reason its	skills that have
	1080	certainly helped me to self harm	lessened self
	1082	less and so I'm probably trying	harming
	1084	out the skills, I guess there's also	
	1086	quite a questionable thing, the	
	1088	DBT service don't need to be	
	1090	doing that sort of thing so even	DBT skills offer
	1092	though that's quite uncomfortable	alternative than
	1094	that's probably quite useful thing	jumping to self-
	1096	01m43 changing the routes a bit	harm
Impact on self harm	1098	rather than automatically jumping	
	1100	to self harm or other things, but	Alternative
	1102	then there's different routes, so	behaviour choices
	1104	its clearly helped me, Ill probably	Self harm used to
	1106	go that route a lot of the time, I've	be every week/
	1108	only done it a few times over the	day, now only a
	1110	last year whereas it used be	few times over

What DBT has taught me	1088	every week, maybe a few times a week, maybe sometimes every	last year
	1090	day so I guess its quite a stark change.	Still distressed –
	1092	Like I was saying earlier, I still	hasn't made her
	1094	feel quite distressed – I haven't	happy to be alive
	1096	quite got to the point where I'm	Disappointments
	1098	happy to be alive, but I do	Sees value of 'life
	1100	appreciate that the DBT service	worth living'
	1102	is trying to build a life worth living.	attempt
	1104	I don't know if you ever get rid of	Past behaviours
	1106	the worn paths in your and	are very
When skills fail	1108	certain thought patterns, I	entrenched
	1110	suppose maybe lessen rather	When distressed,
	1112	than get rid of them. But yeah it's	skills are hard to
	1114	hard when you're in that space is	access
	1116	trying to know what to do.	
Improvements	1118	I: what can DBT do to help you	Service to focus
	1120	when you're in that state?	more on positives
	1122	J: maybe they need to focus a bit	Appreciated
	1124	more on positive things. I mean	writing positives
	1126	they try and make it sometimes	at the end of
	1128		sessions

Useful skills	1112	at the end of the session that we	(<u>Emotion</u>
		all get to say some positive	<u>Regulation</u>)
	1114	things that happened at the end	
		of the week. 03m17 and there is	Positives are
	1116	a section within, its probably in	considered
What DBT has taught me		Emotion Regulation where you	innocuous
	1118	try to write down a few positive	
		things or but maybe there could	
	1120	be more focus on that sort of	Life worth living is
		thing, but again there's an awful	about inner
	1122	lot of things that have been good	happiness, has
		things and I'm really sad they're	DBT touched that
	1124	quite innocuous. I'm seeing a	part?
		lady to try and work out a bit	
		more for a career or training to go	
		for and I'm sure in some ways	
		that helps, but there's still	
		something more to making life	
		worthwhile than job or friends	
		even there's a whole other inner,	<u>Distract/ Self</u>
		I don't really know.	<u>soothe/ Mastery</u>
			have been good
		I: is there anything that the skills	<u>Distract</u> takes
		that have helped you? Particular	mind off
		skill?	difficulties

Useful skills		J: I think a lot with the Distract/ Self Soothe area and the Mastery that's quite a good one actually and that's a really nice way as well, but the distract is really trying to take your mind off things, with the mastery does a lot for me and that's probably gone a lot towards making a life worth living, to feel that you've got goals and that you can achieve them.	<u>Mastery</u> is very useful and gone along way to making life worth living, develops goals and achievable, direction
Useful skills			
What DBT has taught me			

Appendix 6

Reflections

REFLECTIONS

The decision to generate new (qualitative) data was based on the realisation that existing (quantitative) data collected by the service was insufficient, erratic and unreliable. This was the result of the inconsistent way in which the clients filled in Skills Diary and DBT Skills cards, making comparison across clients, as well as across time, unreliable. In the process of generating new data, the service is alerted to new areas for possible evaluation, for example, the teaching of Distress Tolerance skills. It also allows the service to improve on the skills cards themselves to increase homework rates and reliability. However it should be noted that the data may not correlate with what the service deems as most useful, particularly amongst those within the funding structure who are perhaps more concerned with qualitative figures reflecting number of self-harming incidents, for example.

I was aware that my desire to be useful to the service coloured the enthusiasm with which I conducted interviews, and may have had some impact on the social desirability of answers. I was therefore very careful when coding, so as not to artificially bias themes in favour of a positive outcome. However I became aware that none-the-less, themes did map somewhat onto the areas around which the questions were designed. This was managed by asking supervisors to review thematic decisions.

Mruck & Breuer (2003) warn that interview data are co-created through listening, sympathizing and mirroring between participants and researchers. Seen in this way, the transcripts and potentially the themes generated are

contextually situated and thus, rather than reflecting the experience of clients of the DBT service, they are a reflection of clients experience as mediated through their experience of me at the interview. This potentially lowers the validity of data to the service, however allows me to reflect on the process of its creation and how my enthusiasm may have sculptured the answers given. However, given that I am unknown to the members of the service, it may be that participants would feel less concerned about being honest about negative feelings towards therapists, the group or the service.

I am left wondering about the continued incidence of self-harming as reported on trust incidence systems. Though I do believe that DBT has changed the lives of those who have experienced it, I am concerned that, given the relationship between myself (as an unknown researcher, potentially in a position of power) and the clients, responses may have been overly optimistic and sometimes edited.

On reflection of the themes I see that in some ways they reflect the questions posed and that Braun & Clark (2006) ask researchers to be aware of this in analysis, however I believe that the themes are a true reflection of the data gathered. This highlights the ways in which interview questions are framed and again suggests that data is co-created between researcher and participant (Mruck & Breuer, 2003).

I am also cognizant of the ways in which my perception of the client group has changed by working within it. While initially my perceptions of their capacity

for change was coloured by the somewhat negative opinions and attitudes of some fellow professionals, I have witnessed evidence that challenges the permanency of the label of BPD.

Appendix 7

Report and recommendations to the service

EXECUTIVE SUMMARY REPORT

Objective: Various government bodies (eg. NHS Health Advisory Service, 1997; Department of Health, 1999) have focused on the importance of involving service-users in assessing their standards of care. The commissioning trust are interested in the impact of the DBT service on service-users' self-harming behaviours. This exploratory qualitative study was designed to assess from the clients' point of view, the process and outcome of taking part in the DBT service.

Method: All nine DBT clients were invited to take part in one to one interviews. The six clients who agreed to take part were given full informed consent. They were then interviewed and their answers audio recorded. All clients were given a pseudonym to ensure anonymity. Qualitative methodology was used to analyse the transcripts.

Results: Five themes were evident in the transcripts:

1. Positive Experiences.

Clients felt overwhelmingly positive about their experience of the service, the therapists, group and the DBT skills themselves. All were very grateful for taking part in the service and would recommend it to others with a diagnosis of BPD. All clients agreed that DBT was better placed to help them with their difficulties than any therapy they had previously been offered. They were particularly appreciative of learning skills that, as people with a diagnosis of BPD, they have never been taught.

Clients were particularly complimentary of Mindfulness as it provided a framework on which to build all the other skills. Emotion regulation and Distress tolerance were both praised by clients, however they were also deemed very difficult to master. These skills, together with Self-soothing, Dear Man and Distract were credited with lowering the frequency of self-harming behaviours, including illicit drug use.

Homework, although sometimes difficult to complete, was felt to be helpful in practicing and reinforcing skills, as were the laminated cards. Experiences of one-to-one therapy were overwhelmingly very positive, while the group was valued as a source of support and peer learning. Some clients felt that the DBT telephone was imperative in preventing self-harm. Role-play was deemed to be useful in practicing skill usage, particularly those related to Interpersonal relationships.

2. Things I struggled with

Most clients reported finding it difficult to use the DBT skills when they were very distressed, although some were more successful in adapting skills to situations.

All alluded to the difficulty of learning how to respond emotionally and behaviourally in new ways, but agreed that mastering these skills would prove useful. Some clients felt that there was a pressure to complete a lot of homework, while others completed it so as to avoid embarrassment in the

group. All clients continue to struggle with incorporating new skills into their daily lives. The extent to which this is true differs across the client group.

3. What DBT has taught me

DBT has improved the lives of every one of the six clients interviewed. All mentioned an improved ability to regulate emotion and emotional reactions as well as improved interpersonal relationships with partners, parents and co-workers. The service offered each client a new sense of mastery and self-esteem, often for the first time. All clients were benefiting from relationships with caring, non-judgemental therapists through improved self understanding, as well as communication skills. The psycho-educative aspect of DBT teaching was thought to be very useful in understanding the self and others.

4. What I'd like to see after DBT

All clients agreed that an after-DBT service would be useful in reinforcing skills usage. Those who had completed the service were very keen to brush up on their skills, feeling alone after the end of the official service, while those still in the service were conscious of feeling anxious about terminating the service in the future. Ideas on how this service would look differed, but all felt its necessity.

5. Improvements

Clients made various suggestions to improve the teaching of skills. Most notably it was felt that Distress tolerance and Emotion regulation would benefit from being taught with greater attention to individual skills. Clients

would appreciate if skills acronyms were carefully explained at the beginning of skills sets teaching and that they were carefully delineated on skills cards. It was felt that this would facilitate better understanding and greater recall of skills when clients are distressed.

Conclusions: Overall an excellent service is being provided to clients. Clients are very grateful for the level of commitment of therapists, and are very pleased with the content and process of the service provision. If skills cards are accurately and regularly filled in, future qualitative evaluation of service provision would also be possible.

RECOMMENDATIONS TO THE SERVICE

The last theme – Improvements – maps almost directly onto recommendations to the DBT service.

1. Improve the layout of the Skills Diary sheets and homework cards.
Explain all the acronyms when the sheet is first presented and regularly thereafter so that clients get used to the acronyms as soon as possible and are not confused about whether they have covered certain skills or not, or what the letters stand for. Group skills more clearly on the Skills Diary cards to avoid confusion between skills groups.
2. Recognise that emotions are variable throughout the day, and that thus Skills Cards do not adequately reflect client's experiences across the day or week. Perhaps find ways to represent this variety on the cards.

3. Explain all components of a skills group before teaching any one component so that clients feel situated in the skills and are not confused by the variety of skills.
4. Try to keep the one-to-one therapist and therapy constant and avoid taking breaks that are too long as this interferes with skills generalization and the therapeutic relationship and clients may fall back into old behaviour patterns. Should this occur, try to find an urgent replacement.
5. Think of ways of encouraging the use of the DBT telephone for newer members so that it becomes an early crisis intervention technique and not one used only by those who have completed or are completing in the service. Given the reticence of some clients to make contact or seek help when distressed, this would be a valuable learning and may avoid later reliance on telephone contact.
6. Maintain the heterogeneity of group members, observers and therapists as variety of input has been praised by clients. However, try to keep one-to-one therapists constant throughout the 18 months as this was valued by clients.

7. Focus more on the teaching and usage of Distress Tolerance and Emotion Regulation as these skills are very useful but difficult to learn and implement.
8. Given the difficulty of collating good quantitative measures of client's experiences and thus the decision for a qualitative evaluation, a more rigorous and standardized approach to data gathering could be implemented to facilitate future evaluation.
9. Focus on the positives (such as coping skills used and learnt) in each group session, as some clients felt that there was more focus on skills failure than a celebration of skills used. This feels undermining.
10. Ensure that mindfulness practices form part of each and every group session and try not to exclude anyone from these practices as they feel judged and excluded. Ensure that mindfulness is used as a 'wind-down' at the end of every session as emotions run high during discussions.
11. Continue to use role-play as it is deemed very useful in negotiating skills generalization and facilitating the learning of interpersonal skills.
12. Consider setting up an after-DBT support group, facilitated by a therapist known to the group and on a semi-regular basis. This could be once a month to once in 6 weeks and focus on reminding clients

about skills. This is particularly important for Distress Tolerance, which some clients find difficult to manage, especially without therapist support. This group could also include a mindfulness session to encourage its continued use at home.

13. Are there national DBT and BPD services that could be tapped into to create a national self-help website for potential, current and ex-DBT service users to provide practical skills support and education? Consider using new technology to facilitate the teaching of skills (podcasts, social websites).

Appendix 8

Thematic Analysis Phases

Phases of Thematic Analysis (Braun & Clarke, 2006)

1. Familiarisation with data
2. Initial Codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Report writing

Qualitative Report Abstract

How is the NHS socially constructing feeding newborn babies?

July 2010

Year 1

Word count: 245

BACKGROUND: Mothers are bombarded with advice from many sources regarding the best way to feed their newborn baby. Messages of the relative risks of newborn feeding practices have become more prominent in recent years, with health authorities presenting the culturally dominant message that “breast is best” (Murphy, 2003; Wolf, 2007), and that formula-feeding is risky and against health professionals advice (Lee, 2008).

METHOD: Using Foucauldian Discourse Analysis (FDA) we analysed a widely available NHS information booklet to investigate the power of discourses on breast-feeding presented by the NHS. In light of the literature reviewed, discourses around newborn feeding appear to have a powerful influence on how mothers socially construct themselves as mothers.

RESULTS AND CONCLUSIONS: Data was analysed according to the six stages of Foucauldian Discourse Analysis (Willig, 2001). Six *Discourses*, were identified, all placing breast-feeding in opposition to formula feeding and emphasising the health and psychological benefits for the baby. *Action Orientation* revealed positioning breast-feeding as natural and therefore superior. As a result this meant that mothers are positioned in such a way as to feel an imperative to breast-feed. In *Practice* this means that the new mother is left with a choice: she either endorses supposedly neutral NHS practices/research and breastfeeds her baby, or she rejects the evidence for the psychological, physical and emotional wellbeing of her baby and formula-feeds. *Subjectivity* means that the *moral breast-feeding mother* is set in contrast with the *amoral formula-feeding mother*. Limitations of the study, reflections and implications for NHS practice are also discussed.

Major Research Project

**Death and the pub: A discourse analysis of men's talk about mental
health, mental illness and mental health services**

(19,990 words, excluding cover sheet, contents, abstract, acknowledgements,
references and appendices)

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

Department of Psychology
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July 2012

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ABSTRACT

Introduction: Men's health is in 'crisis' (Courtenay, 2003). In light of recent UK statistics around suicide rates, where of 6,000 suicides per year, three quarters are men, and reduced usage of mental health services (MHS) including IAPT (Improving Access to Psychological Therapies) in comparison to women, this crisis extends to men's mental health (MH). **Participants:** One focus-group of seven men and six individual interviews were conducted with young working-class British men in the South-East of England. **Design:** A critical discursive psychology approach (CDP) allowed for consideration of the ways in which men construct their MH so as to consider their relationship with mental illness (MI) and usage of MHS. **Results:** Two over-arching interpretative repertoires were presented: *Masculinity* and *Threats to Masculinity*. Four ideological dilemmas were identified: *I'm not a typical male*; *Mental illness is categorical/ on a continuum*; *Mental health services threaten/ support constructions of masculinity*; *As a man, if I have everything, how can I be depressed?* Four subject positions were identified: *Traditional machismo*; *I'm not a typical male*; *He just isn't right in the head* and *Part-timer*. **Conclusions:** Men constructed their views and attitudes to MI, MH and MHS in relation to constructions of masculinity. This allowed only for certain MH behaviours, constrained by hegemonic constructions of strength and resilience. MHS were characterised as spaces of 'weakness' and were rejected as not conforming to traditional masculinity. Results were discussed in relation to previous research. Advice for MHS included adaptation to accommodate for male-specific constructions.

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INTRODUCTION

The approach to language taken in this research is that it is a medium of social action rather than a code for representing thoughts and ideas, as some psychologists have conceptualised it, or a grammatical system, as linguists usually understand it (Potter & Wetherell, 2005). As such, this research focuses on how men talk about mental health (MH, henceforth), mental illness (MI, henceforth) and mental health services (MHS, henceforth). The main concern being how men “do” MH (for a full list of acronyms see Appendix E).

MH can be defined in many different ways. One definition is a competent expression of feelings, responsibility and autonomy, self-awareness and growth, interpersonal competency, a mature attitude and a capacity for forgiveness (Masters & Bergin, 1992). MI will be defined in the new DSM-V as a behavioural or psychological pattern within an individual reflecting an underlying psychobiological dysfunction causing clinically significant distress (DSM-V Development, American Psychiatric Association, n.d.). It will be described as more than an ordinary response to life stressors and not primarily the result of social deviance. MHS refer to primary, secondary and tertiary MHS in the UK. These definitions are not exhaustive; they are working tools to help contextualise the research and acknowledge the contribution of health literature to this area.

To guide the reader through this introduction, the section has been divided into two parts. Part One will consider current literature in men's MH and use of

MHS, addressing the 'crisis' in men's health and men's help-seeking behaviour (HSB, henceforth). It will address men's use of MHS and argue that men's MH is in need of consideration. Part Two will consider how a 'turn to language' is a helpful way of considering men's MH, attitudes to MI and their use of MHS.

The research will take a critical approach to gender and will argue that masculinity is tied up with constructions of MH, MI and the use of MHS. The exploration of this topic is imperative to clinical psychology as it can aid MHS in developing new strategies and ways of communicating with people who may perceive these services as problematic. In contrast to much of the literature on men's MH and their use of services, this section does not treat either MH or MHS as natural phenomena, but rather as socially constructed.

Finally the introduction will develop a rationale for this study, the analytical tools used to undertake it and the research questions used to guide it.

Part One: Current Literature on Men's Mental Health

This section will summarise current literature and research around men's MH and use of MHS. It will consider research into men's help-seeking behaviour (HSB), gender socialisation and masculinity and gender theory.

Research linking gender and health has a long history, with debates raging since the 1970s (Hayes & Prior, 2002). The 20th century feminist movement spurned a plethora of studies on women's issues and health, however rather

less on men's health (Hayes & Prior, 2002). The relationship between gender and health services usage began to find credence in the 1980s however as a result of observed differentials in men's use of services. The 1990s then saw an increase in the number of studies comparing men and women's experiences in various areas of health, including MH (Lahelma *et al.*, 1999; Prior, 1999).

Concerns about men's health in the late 20th century, including their MH, suggested that men's health was in 'crisis' (Courtenay, 2000). This was the starting point for studies into men and masculinity, following what became known as a 'crisis of masculinity' (Kahn, 2009). The adoption of a masculine ideology is defined by Good *et al.*, 1994 (p.3) as:

an individual's degree of endorsement and internalization of cultural belief systems about masculinity and the masculine gender role.

Statistics from the mid-1990s showed that there was an increase in admission rates for young men in inpatient MH facilities in England and Wales (Meltzer *et al.*, 1994; Kessler *et al.*, 1994) suggesting that men's health was indeed in crisis. An analysis of census data from 1991 showed that the proportion of MH beds was higher for men than for women in both countries for the first time (Kessler *et al.*, 1994). Although women had predominated in institutional MH care for most of the 20th century, since the early 1990s, men and women

seemed to be using services equally (Kessler *et al.*, 1994). Men's use of psychiatric services had also increased.

Statistics supporting a crisis in men's MH are very persuasive. Suicide continues to be the leading cause of death amongst young men aged 15-35 in England and Wales (Powell, 2010; MH Forum, 2011). 75% of all people who die by suicide in the UK are men (Office of National Statistics (ONS), 2010), and the male: female ratio is at least 3:1 internationally, and in Belarus is as high as 6.69:1 (Kingerlee, 2011). Suicide accounts for as many as 4,000 male deaths each year in the UK (The Samaritans, The Scotsman, 9 September 2010). Importantly, most are not accessing any form of MH service at the time of their death, and many deny having a MH problem (Kingerlee, 2011).

Furthermore there is a well-documented differential between community and clinical samples (Conrad & White, 2010, p.10). For every four men diagnosed with depression in 2000 there were ten women (ONS, 2000). However community samples tell a different story. Singleton *et al.* (2000) for example found that for every ten women with depression in the community, there were in fact eight men. This suggests that men are not identified, nor are they presenting to services.

Interest in the link between male gender roles, MH and risky behaviours took off in the 90s. One of the starters was the addition of alcohol and drug dependence statistics as indicators of MH concerns (Courtenay, 2000). Men continue to commit 87% of violent crime and 94% of the prison population is

male (*Untold Problems*, 2010). Inclusion of these statistics furthered theories of men's externalising behaviours as indicators and coping strategies around psychological distress (Kingerlee, 2011). In their own research with service users, MH charity Rethink (2006) found that 'one in three men would rather smash something up, than talk about their feelings'.

Men's use of mental health services

Many studies demonstrate that women are more likely than men to receive treatment for MH problems (e.g. Elhai *et al.*, 2006). Large-scale epidemiological studies (e.g. Kessler *et al.* 1994) however show no overall difference in the rates of psychopathology in men and women (Rosenfield, 1999). Despite the prevalence of MHS, Rethink (2006) reported that 67% of suicidal men interviewed felt they had 'nowhere to go for help'. Furthermore, 51% of men do not visit their GP in the week before their suicide (Kingerlee, 2011). This suggests that unlike women, men do not see MHS as a viable HSB strategy in times of psychological distress.

Research has consistently found that compared to women, men have more negative attitudes to seeking help for all aspects of their health, and are thus less likely to do so (McKay *et al.*, 1999; Berger *et al.*, 2005). This is exacerbated because services tend to cater for women rather than men, possibly because of wider use by women (Kaplan & Sadock, 1995), creating a self-perpetuating problem. Furthermore, men have been found to experience stigma when accessing psychological help as the therapeutic environment is itself deemed as feminised (Moller-Leimkuhler, 2002; Vogel, *et*

al., 2007). Good *et al.* (1989) found that men experience rejection both for experiencing sad emotions and for seeking help. Corrigan (2004) argued that stigma associated with MI is the most common reason why people avoid approaching services for psychological problems, while Kimmel (2001) explains this by claiming that Western masculinity is organised around avoiding shame.

Recent research by the charities Mind and Men's Health Forum suggests that women predominate in their use of primary care MHS, while men, particularly younger men, continue to be largely absent from these services (*Delivering Male*, 2011). A 2008 study into two pioneering IAPT (Improving Access to Psychological Therapies) test sites found that men were under-represented (Clark *et al.*, 2008). Only 35% of referrals were men, indicating a problem at primary-care level. The study concluded that men were 'not attracted' by services, however it did not go into the reasons for this. A more recent study concluded that the gender ratio for MHS was just fewer than 2:1 (NHS, 2009), this being 'particularly true of young men.'

Working-class men

Suicide rates amongst young men increased in the UK and other countries in the Western world from 1975 to the 1990s, most evidently amongst men aged 15-29 from 'disadvantaged areas' (Kaplan & Sadock, 1995). Both urban and rural working-class men continue to be identified as being particularly at risk (Young, 2010; Robertson *et al.*, 2010). Rural communities suffer lower levels of healthcare provision, particularly in specialist services, and a lack of

information about MH (Robertson *et al.*, 2010). Low-income urban men face psychological pressures related to 'structural, systemic, behavioural [including a lower likelihood of help-seeking] and attitudinal factors' (Young, 2010, p. 40). Furthermore, cross-cultural research has repeatedly shown a relationship between poverty and HSB (Young, 2010).

Campaigns promoting men's mental health

Findings such as these led to a number of topical national campaigns aimed at capturing working-class men's attention. For example, The Samaritans' *Men on the Ropes* (2010) was launched in collaboration with Network Rail as a response to an increase in the number of male suicides along their railways. It highlighted the vulnerability of men from deprived backgrounds, and resulted in a national media drive to target male suicide. Recently the crisis in men's MH has been further highlighted through various high profile sports and media men (perhaps most recently Duncan Bell, Averis, 2012) drawing attention to the prevalence of (and silence surrounding) MH issues amongst working-class men (The Guardian, 17 April 2012).

In 2006, 41 UK organisations with concerns around men's MH developed the *Brain Manual* (Banks, 2006), to recognise the state of men's emotional and MH. Men's Health Forum also highlighted men's MH in their National Men's Health Week (Wilkins, 2006). In 2009, the charity Mind dedicated their MH week to men's MH, issuing the *Get It Off Your Chest* report based on focus-groups drawn from two working-class urban centres. Helpline and website CALM (Campaign Against Living Miserably), offering counselling to young

men at risk of suicide, was launched in London in 2011. Set up in response to DoH research findings that young men were 'turned off' by the MH help offered, CALM experienced considerable success in Merseyside in halving suicide rates in young men in 10 years (NMH DU, 2011). In order to attract them, CALM spearheaded a series of successful eye-catching advertising campaigns, designed by leading agency Ogilvy & Mather. It was fronted by some recognisable media faces - including sports and music stars and comedians - and strategically placed within pubs, clubs and pizza parlours. The messages were hard-hitting and visuals exciting. While calls to CALM's helpline increased, it is more difficult to calculate the impact on MHS.

Help-seeking behaviour

As has been established, many studies demonstrate that women are more likely than men to access treatment for MH problems (e.g. Elhai *et al.*, 2006). Various studies have found that men find it harder than women to request psychological help (e.g. Perlick & Manning, 2007). Men are also less likely to seek help from psychiatric and counselling services (Courtenay, 2000). It is not news that men are reluctant to seek help in relation to both their physical and MH. National UK reports state that men are less likely to visit their GPs than women, and this is particularly true for those aged 50 and below (Information Services Division, 2000; National Health Services Executive, 1998).

Mind therefore has conducted numerous studies specifically into men's MH and their access to MHS (*Get it off your chest*, 2009; *Untold Problems*, 2010;

Delivering Male, 2011), spearheaded by national policy documents such as The Equality Acts (2006, 2010). Results published in *Get it off your chest* support the fact that men are reluctant help-seekers. Based on a survey of 2,000 men and women service-users and focus-groups in two locations in England, they found that only 23% of men who said that if they felt low for more than two weeks were likely to visit their GP, compared to 33% of women. Men were also half as likely to visit a counselor and young men were almost twice as likely (16%) as women to drink alcohol in times of stress. While 53% of women said they would talk to their friends about their problems, only 29 % of men said that they would. How can we account for this discrepancy?

Accounting for differences in help-seeking behaviour

Pleck (1981, p.1) suggested that the paradigm of sex roles, particularly that of the male sex role identity (MSRI) prevalent in the social sciences since the 1930s, has shaped psychology's view of masculinity and HSB. Influenced by psychoanalytic concepts on the role of the unconscious in compensating for perceived feminine characteristics, research into the MSRI lasted into the 1960s. It was largely replaced by the conception that masculinity and femininity, rather than existing on the same continuum, were two separate psychological concepts. Within traditional psychology, both uni-factor and two-factor theories of gender argued that the closer an individual's behaviour is in respect to the 'expected social role', the healthier they are (Pleck *et al.*, 1993). Some male-specific models of men's psychological health were proposed as a result (e.g., Cochran & Rabinowitz, 1996; Good & Mintz, 2005; Kendler *et*

al., 2006; Mahalik, 2005a, 2005b; Pollack, 2005, Kingerlee, 2011). The male specific profile (MSP), adapted from Young *et al.* (2003), is one attempt to explain male HSB and synthesise research into men's experiences of MH. The MSP suggests that men in general tend to be more concerned with seeking status than care-seeking (Kingerlee, 2011). They are less likely to expect help, more unwilling to accept help from services, more emotionally inhibited, and are more likely to associate emotional distress with shame (Young *et al.*, 2003). The MSP was expanded upon by Addis & Mahalik (2003), who argue that there are three theories about why men do not seek help when they require it. The first is that men are not good at detecting signals. The second that men feel uncomfortable in discussing their concerns. The third that help-seeking clashes with beliefs about masculinity. Some of these explanations have been criticised as two-factor theories of gender, measuring only the characteristics of masculinity that the researchers deem are part of masculinity (Kahn, 2009).

Other accounts for differences in HSB include biological dimorphism in brain neurology, such as theories about the extreme male brain (Baron-Cohen, 2011), which is deemed less empathic because of differences such as a smaller limbic cortex (Goldstein *et al.*, 2001). Male developmental factors such as differences in parent-child micro-interactions are also cited. For example mothers of girls have been found to be more sensitive and structuring of emotion (Bornstein *et al.*, 2008) and boys have been found to be less likely to express hurt or ask for help from parents and teachers (Benenson & Koulmazarian, 2008).

Brownhill *et al.* (2005) suggest that the gender difference in depression rates can be understood not so much in terms of how it is experienced, but rather how it is expressed. They describe the '*Big Build*' model which suggests that gendered practices allow for particular ways of communicating depression, showing how masculine depression might result in escalating behaviour – avoidance (such as overworking), numbing (self-medicating), escaping (extra-marital affairs), acting out (aggression) and ultimately self-harming (Branney & White, 2010).

Gender socialisation provides an explanation of learned gendered behaviour. Rather than being taught to seek help, this explanation suggests that men learn to be masculine. In order to do this, they learn to be 'self-reliant, physically tough and to restrict emotion' (Levant & Richmond, 2007; Levant *et al.*, 2007) through interaction with parents and peers. Much research suggests that men's socialisation promotes self-reliance in problem-solving, and an absence of perceived weakness and vulnerability - all factors that could prohibit use of MHS (Mahalik *et al.*, 2003; Rochlen *et al.*, 2005). Feelings such as being sensitive or hurt are traditionally viewed as feminine characteristics (Bem, 1974) and are rejected. Men then tend to see emotional expression as the failure of rationality (Crossley, 1998) and, together with perceptions of appropriate gender-role behaviour and media pressure, this may result in internalising emotions (Branney & White, 2010). Through socialisation, men then come to believe that help-seeking will infringe on core masculine traits such as independence and emotional rigidity (Addis &

Mahalik, 2003). Thus, constructions of masculinity play a role in HSB. This point will be examined next.

Part Two: Rethinking Men's Mental Health: A 'Turn to Language'

In this section, it will be shown that the ways in which masculinity is socially constructed provides an explanation of men's experiences of MI and use of MHS. In this way, it can be argued that the characteristics that are considered masculine are constructed through language within specific social situations.

The social construction of masculinity and mental health

Social construction (SC, henceforth) perspectives on gender differences in MH statistics are related to the different ways that MH professionals and society, including men, conceptualise masculinity and MI (Hayes & Prior, 2002).

Research suggests that men are 'prevented' from seeking psychological help for depression as this is viewed as 'unmanly' and 'weak' (McCusker & Galupo, 2011). Within the UK, cultural norms, including the perception that men should not show vulnerability, affect men's view of MH and their likelihood of seeking help (*Delivering Male*, 2011). Psychosocial explanations therefore suggest that differences in reportage between MH in men and women are differences in HSB, rather than in prevalence (Courtenay, 2000; Macintyre *et al.*, 1996), and that these are related to constructions around masculinity.

The relationship between adherence to masculinity norms, men's HSB, and their health has been the subject of many studies. For example, various

correlational studies have shown that negative attitudes to psychological help-seeking and depression are associated with men's adherence to traditional gender roles (Courtenay, 2003; Good & Wood, 1995; Pederson & Vogel, 2007; McCusker & Galupo, 2011). The impact on men's MH and HSB of adherence to traditional masculine gender roles is well documented (e.g. McCusker & Galupo, 2011). Recent cross-cultural research has found that men who adhere to traditional masculinity perceive more barriers to help-seeking (Mansfield *et al.*, 2005; Boman & Walker, 2010). *Untold Problems* (2010, p. 14), a Mind document, found the relationship between men's MH and masculinity to be particularly salient:

... there are often significant tensions between conventional masculine behaviour and the idea of nurturing good MH. Admitting the need for support with emotional and psychological problems may be a particular challenge for some [men].

These concerns have been replicated elsewhere using both qualitative and quantitative research methodologies. For example, O' Brien *et al.*, (2005) found that on conducting focus-groups about their MH, there was a strong reticence to discuss depression within the groups, particularly amongst those consisting of young white men. In research, young men present what has been termed 'an impenetrable wall of machismo' (Branney & White, 2010, p. 18) to any discussion around MH. In a quantitative study of 155 men Berger *et al.*, (2005) found that negative attitudes to help-seeking were predicted by traditional masculine ideologies rather than by gender role conflict.

Research suggests that men may react more stoically and less expressively to their experiences of mental problems, since 'displays of anxiety and depression' may be viewed as 'relatively unacceptable' within traditional conceptualisations of masculinity (Rosenfield, 1999, p. 359). Adhering to traditional masculinity may therefore be 'intuitively antithetical to the behaviour of seeking help for psychological concerns' (Good *et al.*, 1989, p. 295).

However, many researchers consider "traditional masculinity" and "masculinity" to be a social construct (e.g. Walton *et al.*, 2004). That is, how people talk (or use discourse) about something, like gender, in a particular historical, socio-cultural context may help maintain certain understandings and behaviours. In this case, how people talk about what it is to be a man may play a role in constructing "masculinity". Equally, how people talk about MH might play a role in how MH is perceived. Therefore, how talk or discourses in our society encourage these perceptions and/or behaviours can be the object of study (Potter & Wetherell, 2005). In this research they are the focus of study, and to situate them as such, a brief background into discourse and psychology will be given below.

Discursive psychology

Discursive psychology (DP, henceforth) is interested, amongst other things, in how gender is being exclusively created in particular situations (Khan, 2009). DP is not a unitary church of ideas, but is made up of a variety of arguments that are sometimes contradictory (Edley, 2001, p.189). DP was influenced by feminist thought and combines methods from various approaches (Gill, 1995;

Speer, 2001). At its heart it places language, and so discourse, at the centre of psychological study (Edley, 2001). Rather than the traditional psychological view that language provides insights into individual's thoughts, feelings and attitudes, DP sees language as the object of study (Potter & Wetherell, 2005). It is through language that DP believes people are constructing themselves and others, in highly context-specific ways (Potter & Wetherell, 2005). DP considers the language used by people (in this case men) to understand how their social relationships are constructed and understood (Riley, 2003). Language is consequently considered neither neutral nor transparent, but is the subject of analysis and thus actively conveys meaning. DP therefore accredits agency to individuals in using language to 'construct versions of the world' and themselves (Potter & Wetherell, 2005, p. 33).

Discursive psychology and psychoanalytic explanations

Discursive psychology (DP) has been fused with psychoanalytic theory to provide a broader explanation of 'masculine' behaviour. However this synthesis has been criticised since DP argues against essentialist notions of identity, positing that men's identity is fluid (Edley, 2006). Furthermore, in DP thought is understood as 'conversation turned inwards' and therefore the unconscious is not required as another level in understanding men's talk and actions. This will be examined now.

Discursive psychology and masculinity

Understanding masculinity as a construct means that "masculinity" is negotiated in different contexts, primarily through the use of language rather

than as a psychological phenomenon (Kahn, 2001, p. 156). Understood in this way, men's constructions of themselves and of their HSB is seen as 'constructed in and through discourse', rather than as something inherent within men's psyche (Edley, 2006, p. 603). DP therefore provides an alternative explanation of the ways in which men respond to MI and therefore to MHS.

[The] way that language is utilised by participants results in a socially constructed meaning for masculinity which has ramifications for the ways in which we engage those who are understood to identify as men.

Kahn, 2001, p. 156

Since the 1980s, there has been growing interest in the role played by discourse in constructing masculinity (Edley, 2001). In recent years, an increasing body of research has used a discursive methodology to study men and masculinity (e.g. Edley & Wetherell, 1997, 1999; Frosh *et al.*, 2002, Gough, 2004). Through discourse, some ways of talking about masculinity and MI are considered more accurate than others, and are therefore given more credence (Edley, 2001).

Within DP, masculinity and help-seeking is accomplished within social interactions, challenging essentialist and reductionist understandings of gendered behaviour (Edley, 2001). MI and HSB are therefore considered fluid and related to the contexts in which men find themselves (Edley, 2001, p.

192). According to this understanding, masculinity, or the way men view how they should behave, is not static, but a changing reflection of the social context (Ruspini, 2007). To study this dynamic process a discourse analytical approach is necessary, as it will be seen next.

Discourse analysis

Discourse analysis (DA) is a research methodology that takes a discursive approach to its subject. Within social psychology, DA has its foundations in philosophy, sociology and linguistics (Potter & Wetherell, 2005). Like DP, DA belies easy definition and has become 'an umbrella term for a wide variety of different analytic principles and practices' (Edley, 2001, p. 189). In this research, 'discourse' is used in its most open definition, referring to any spoken interaction or written text, and DA therefore refers to an analysis of any form of discourse (Potter & Wetherell, 2005, p.7).

Critical discursive psychology

Critical discursive psychology (CDP) extends analysis outside of the specific interaction, considering how conversation is embedded in an historical context, and how language used is a product of that history (Edley, 2001). Though individuals are considered to have agency in what language they choose to use from the variety provided by history, this is limited as certain 'ways of understanding the world' take precedence (Edley, 2001, p. 190). CDP seeks to unpick 'the process of normalisation/naturalisation' of language and meaning and to consider whose hegemonic interests these discursive formulations might serve. CDP argues that some ways of talking about issues

of psychological concern, such as how men consider their MH, have cultural dominance, and that these 'can assume the status of facts'; they become taken for granted as '... accurate descriptions of the world' (Edley, 2001, p.190). Instead of regarding men as simply 'being' male, CDP is used to unpick how men engage in ongoing conversations, in various contexts with one another about what it means to be male (Khan, 2009, p.155). Being male and engaging with MHS and MI are considered as interacting and as reflecting wider discourses around masculinity.

Rationale for Study

At the macro level, discursive psychology views masculinities as varying across historical periods and across social groups (Wong *et al.*, 2011). Social constructionist (SC) views of the relationship between masculinity, MH and MHS focus on the contextual and flexible nature of these concepts (Kahn, 2009; Wong & Rochlen, 2008). The study of how these are 'actively performed by individuals in specific social contexts' (Wong *et al.*, 2011, p. 298) is an important determinant at the micro-level (Addis & Mahalik, 2003; Wong & Rochlen, 2008). Therefore the ways in which British working-class men talk about MI and MHS can be seen as a reflection of the contemporary social and cultural context in which they find themselves (Taylor, 2001). In this research, working-class was defined in terms of income, occupation, education and residence (Pescosolido & Boyer, 1999).

SC, through deconstructions of local masculine identities, therefore offers a way of explaining research findings linking HSB to gender (Courtenay, 2000;

2003). As discussed, critical discursive psychology (CDP) makes language its 'topic' of study, and argues that through language people construct the attitudes, emotions and memories about which they are talking (Potter & Wetherell, 2005). Therefore the analysis focuses on the language used by participants to describe MI and MHS. Furthermore, social constructionist theories recognise that gender is something 'done' within social interactions (Conrad & White, 2010, p. 19) and thus analysing talk is well suited to understanding how men construct MI and MHS in their everyday speech. Traditional psychology would argue that attitudes, beliefs and actions in relation to MH and MHS would be a bi-product of masculinity (Edley, 2001). This research suggests that men are actively constructing masculinity by and when adopting these attitudes, beliefs and actions.

Furthermore, CDP analyses how historical context provides some constructions with apparent legitimacy, so that they assume the 'status of facts' (Edley, 2001, p. 190). As such, the use of CDP allows the researcher to enquire further into 'whose interests are best served by different discursive formulations' (Edley, 2001, p.190).

Aim/ Research Question

To this end the aim of this research was to add to the body of literature studying and relating gender, MH and the use of MHS using a discursive perspective. Thus, the question posed in this research was: how do men construct MI and use of MHS?

To answer this question, a CDP perspective was adopted. Previous studies have used discourse analysis (DA) in exploring how men view their health (e.g. Sloan *et al.*, 2010; Crawshaw, 2007), while others study emotion (e.g. Walton *et al.*, 2004). None have used CDP (based on Edley, 2001) to address men's constructions around MI and MHS within the local British context with young white working-class British men.

MHS, including IAPT, are not seeing as many men as women (DoH, 2009). It has been argued that this is because MHS do not adequately understand the needs of men and that this impacts on men's uptake of IAPT services, on inpatient stays, and on male depression and suicide rates. Using a CDP methodology was thus considered helpful in informing NHS policy and campaigns on how best to approach men.

The method of data collection was a focus-group and interviews. Both methods have previously been used with DA in relation to masculinity (Wetherell & Edley, 1999; O'Brien *et al.*, 2005). Focus-groups are popular within DA as they allow the researcher to observe how men "do" masculinity through their talk in social situations (eg: Walton *et al.*, 2004). Furthermore they are perceived as 'low threat' by participants (in comparison to other methodologies) and they allow the researcher to probe responses in real-time (Krueger & Casey, 2009). Interviews in DA allow men to feel freer to discuss difficult topics without the 'policing gaze' of other men (eg: Sloan *et al.*, 2010).

METHOD

Participants

Participants were recruited using a snowballing technique and through a poster and handout advertisements (Appendix B) (Reynolds & Wetherell, 2003). Recruitment posters and handouts were placed in local newsagents, a restaurant, a gym, a Job Centre and a local college. Relevant permissions were obtained. Only one participant was recruited through this method, the remaining twelve were recruited through friends and acquaintances whereby the researcher invited female friends to suggest male acquaintances who matched the participant criteria to take part in the research (Reynolds & Wetherell, 2003). Participants were not known to the researcher prior to the research.

Inclusion criteria were that men were British born, aged 18-35, and self-identified as white British and working-class or from a working-class background. Men were excluded if they said they had had a MI or were currently receiving treatment for a mental health-related issue. Pseudonyms were given to all participants (see Table 1 and 2).

The non-clinical 'typical' British (Taylor, 2001) sample size of thirteen was determined by previous sample sizes for similar studies (e.g. Sloan *et al.*, 2010; Walton *et al.*, 2004). Six men aged between 20-35 were interviewed. The focus-group consisted of seven volunteers aged 29-32. Typically focus-groups consist of between six and 12 participants (Gast & Peak, 2011).

Interviews have also been used in DA. For example, in their discourse analysis entitled *Healthy Masculinities? How ostensibly healthy men talk about lifestyle, health and gender*, Sloan *et al.*, (2010) interviewed 10 men, while Walton *et al.*, (2004) conducted two focus-groups, each consisting of 6 men for their study entitled *Death and football: An analysis of men's talk about emotions*. Sample size was also informed by being aware that DA data can be difficult to interpret and analyse succinctly, and smaller sample sizes are often deemed appropriate (Taylor, 2001).

Pseudonym	Age	Profession
Sean	32	Carpenter and joiner
Sebastian	32	Maintenance electrician
Gerard	30	Print manager
Edward	29	Manager: highways
Michael	31	Control room team leader
Joshua	30	Sign writer
Douglas	30	Highway steward

Table 1: Focus-group participant demographics

Pseudonym	Age	Profession
Jeremy	20	Trainee accountant
Serge	29	Music teacher
Jason	28	Sales representative
Colm	27	Special needs support worker
Charlie	23	Removals van driver
Dean	35	DJ

Table 2: Individual interview participant demographics

Ethical Procedure

The research proposal for this project underwent peer review through a panel of Clinical PsychD tutors at the University of Surrey. The project also obtained a favourable opinion from the Ethics Committee of the Faculty of Arts and Human Sciences at the University of Surrey (Appendix A).

Procedure

All participants were provided with an Information Sheet, Consent Form and Demographics Sheet via e-mail or by hand prior to participation and a Debrief Sheet (Appendix C) after completion of the interview/ focus-group. Full informed consent was given. It was explained to participants that they could terminate the interview/ focus-group at any time. The right to withdraw their data was also explained as being available as an option up until the first draft of the project was written. A prize draw of a £50 gift voucher was offered as an incentive.

Interviews and focus-group

The first source of material for analysis was six audio-recorded and transcribed interviews of men. One interview took place in person and the rest over the telephone. Telephone interviews were deemed appropriate because they allowed for greater convenience to participants, avoidance of embarrassment and ease of administration for the researcher (Settineri *et al.*, 2010). Interviews were chosen as participants were reluctant to engage in

groups with strangers. Interviews lasted between 40 minutes and one hour twenty minutes.

A second source of data was an audio-recorded and transcribed focus-group. Debate exists around whether naturally occurring groups facilitate better discussion within focus-groups (O'Brien *et al.*, 2005). It was decided therefore that, given the sensitivity of the subject area, constructions might be easier to elucidate within a friendship group. Focus-groups have gained in popularity in qualitative health psychology (Wilkinson, 1998). They allow participants to engage in constructions in a more natural environment than a one-to-one interview. The focus-group took place in the home of one of the participants and lasted one hour.

A semi-structured interview technique was adopted for both the focus-group and interviews as it allows for generation of natural responses (Willig, 2008) and discourses (Edley, 2001). The semi-structured interview questions were based on a short list of topics generated after a brief literature search around gender and MH (Watkins & Neighbors, 2007). Semi-structured questions were avoid leading discussions (Appendix D), allowing participants to elaborate in a conversational manner (Riley, 2002, p.447).

Analysis

For analysis, transcripts were read and re-read for recurring patterns around MH, MI and MHS. A file of all discourses was built up (Wetherell & Edley, 2001). Transcripts were then analysed according to the following concepts of critical discursive psychology (Edley, 2001):

1. *Interpretative Repertoires* (Potter & Wetherell, 2005; Edley, 2001)

Interpretative repertoires (IRs) are the 'relatively coherent ways of talking about' (Edley, 2001, p. 198) a particular topic (Reynolds & Wetherell, 2003, p.496). Analysis involved first identifying the patterns, metaphors and figures of speech that appeared across and within the data around men's MH, MI and their use of MHS. Distinguishing IRs therefore involved looking for the everyday, taken-for-granted ways in which men were constructing their discussions with each other (in the case of the focus-group) and with the researcher (in the case of the interviews). These were then analysed further to reveal two separate overarching IRs regarding men's talk about MH and services (Edley, 2001).

2. *Ideological Dilemmas* (Billig *et al.*, 1988; Edley, 2001). This step involved identifying the beliefs, values and practices regarding men's MH that are inherent in contemporary British society and were evident in the ways that men were talking (Edley, 2001). Ideological dilemmas (IDs) are a product of the ways that people argue over the 'competing threads' and 'inconsistencies' existing around socially constructed topics such as masculinity, MH and use of services (Reynolds & Wetherell, 2003). At this stage, analysis sought to

identify the sometimes contradictory ways that participants talked in search of the stock of knowledge that supported their beliefs. These contradictions are said to develop in opposition to each other (Billig *et al.*, 1988) and were therefore analysed in pairs.

3. Subject Positions (Davies & Harre, 1990; Hollway, 1984, Edley, 2001). Subject positions (SPs) are the 'story lines', 'roles' and 'characters' available to us and others (Reynolds & Wetherell, 2003) through IRs and IDs. SPs serve to 'accomplish' something at the local level in which they are produced (Edley, 2001) and link 'the wider notions of discourses and interpretative repertoires to the social construction of particular selves' (Edley, 2001, p.210). In this stage, attention was therefore focused on uncovering the ways that IRs and IDs placed people – their SPs – across the transcripts (Edley, 2001). By looking for SPs, particular male identities in relation to MH and MHS were made available.

To structure the analysis section, an approach used in ethnographic research was used (see Hammersley & Atkinson, 1995). Since too much data was generated from participants to present and analyse in full in this document, the analysis section presents a summary of the data, with examples (Taylor, 2001). Interview and focus-group data was analysed and is presented together since similar results/ discourses were gleaned in each context.

Credibility of the Study

In order to increase credibility, the following steps, recommended by Yardley (2000), were followed:

1. *Sensitivity to context.* The research question was guided by current literature and research into men's MH and their use of services. The research also took into consideration current NHS IAPT practices and concerns through probing participants' understandings of these services (based on the semi-structured questions) and by paying attention to IAPT audit data (Clarke *et al.*, 2008).
2. *Commitment and rigour.* Interview and focus-group data was repeatedly read and considered throughout the analysis phase. The analysis, as well as the categorisation of data was conducted in collaboration with the university research supervisor.
3. *Transparency and coherence.* The analysis includes extracts from interview data to demonstrate thinking. Also the researcher's relationship to the data is considered in the section on reflexivity below.
4. *Impact and importance.* Data generated relates to current NHS practice. The usefulness of the findings within various contexts is also considered.

Relevance to Clinical Psychology Practice

The Mind report *Get it off your chest* (2009) argues that relatively little attention has been given to the psychological concerns of men in the UK. Together with other documents, it advises that health professionals should take gender into account when planning, designing and discussing treatment options, and that gender issues should be part of the training and development of health professionals. Clinical psychologists (CPs) (e.g. Kingerlee, 2011) have also called for the inclusion of male-specific training and therapy.

The critical discursive psychological (CDP) approach to masculinity challenges essentialist, reductionist methodologies, suggesting that gender is constantly being 'remade' through interaction (Edley, 2001). As such it allows those involved with commissioning services for men to challenge the notion that gendered attitudes and behaviour with regards to MH is natural and therefore fixed. Rather CDP allows for flexible, context-specific service responses to men's MH needs at both primary and secondary level. MH professionals would therefore benefit from understanding the interplay between men's constructions of themselves, the context of the therapeutic environment, and the therapist themselves.

CP Andrew White is not alone in arguing that adherence to strict masculine codes of behaviour are often detrimental to men's MH (*Delivering Male*, 2011). For example, seeking psychological help can be seen as 'unmanly, involving discussions about emotions and feelings, dependency on another,

[and] psychological weakness' (Trainee CP, Luke Sullivan, *Delivering Male*, 2011, p. 114). It is imperative for both trainees and practising CPs to consider the ways in which they engage both with male clients, but also with service delivery in unpicking and challenging these assumptions.

Reflexivity

Yardley (2000) argues that qualitative researchers should consider themselves as participants in the research process (Parker, 2005). The use of the term participants suggests that the men taking part in the study are separated from the interviewer. However I recognise that in participating in the discussions, I too am a participant in the construction of the data (Reynolds & Wetherell, 2003). A strong case can be made that the identity of the researcher will have an impact on the collection and analysis of the data (Taylor, 2001). Since detachment in qualitative research is deemed impossible (Hammersley & Atkinson, 1995), that I am a woman conducting this research also needs to be considered (Hammersley & Atkinson, 1995). It is possible that I represent the feminised MHS that participants spoke of, and that that contributed to constructions about services and MH. CDP would argue that discourses are context-related, and therefore this construction is meaningful in itself, having wider implications for MHS uptake.

Even though the participants and I speak the same language, slang and metaphors were sometimes difficult for me to understand. This inadvertently affected analysis (Taylor, 2001). This was particularly true when it came to

sport-related and colloquial language. Here I was forced to consult others about possible interpretations.

Given the sensitivity of the research area, participants may have felt uncomfortable in answering questions and believed they were expected to give particular responses (Taylor, 2001). I was therefore considerate of the setting of the interviews, and felt that participants were more comfortable answering questions on the telephone, where their anonymity was further ensured.

I was also aware that there are different conventions in the transcription of recordings⁶. The way in which I chose to transcribe the data is a matter of selection, itself a part of the analysis (Taylor, 2001, p. 36), and may therefore have inadvertently impacted on the areas that emerged as salient.

Taylor (2001) suggests that the choice of research area is important to consider. It is possible that the selection of the topic of men's MH was partly informed by the scarcity of men I have worked with during clinical psychology training. In line with research, more women presented to the MHS in which I worked. I was also aware of the dearth of clinical training around male-specific MH. More profoundly I have had experiences with various male members of

⁶ Transcription symbols are based on Reynolds & Wetherell (2003, p.507) and are used to ease reading. The symbol [...] is used to signify that text has been omitted, [text] indicates that the author has inserted text, and [.] shows where there is an untimed pause in the talk.

my family who have found it impossible to talk about their MH concerns, sometimes with devastating consequences.

I sometimes found that men's descriptions of their difficulties touched upon my own experiences. The nature of social construction (as the intellectual analysis of dialogue) allowed me to helpfully process these emotions.

RESULTS

Interpretative Repertoires (IRs)

One of the most pervasive patterns in the data was the presence of two IRs, or men's accounts of MH and MI: *Masculinity* and *Threats to Masculinity*. All men, those in the face-to-face interviews and those in the focus-group, drew on both repertoires. These two IRs are discussed below.

Masculinity

Discourses that constructed and maintained the traditional perception of masculinity were present throughout men's talk of MH, MI and MHS. These discourses formed part of the routine way that men talked about masculinity in their everyday lives. The ideas connecting masculinity and MH were presented in various well-worn forms:

A: It's all biological

MI was frequently portrayed in the accounts as inextricably linked with the concept of masculinity. This was achieved in a number of ways. Firstly, MI was constructed by participants as natural, with the terms 'biological' and 'disease' appearing throughout men's discourse. Specifically MI was typically conceptualised as 'a chemical imbalance in your brain' (Dean and Sergei), or 'something you're born with ' (Joshua). This placed MI beyond the responsibility of the sufferer – innate and overpowering. This is evident in the following extract:

Extract 1

Sergei: *[MI is] not something you can make happen [...] there's nothing you can do as an individual you know, you can't make yourself better [.] there's nothing you can do to manage it [...] If you take mental illness it's two words, it's mental and it's illness, the illness part is illness, the mental part just means it's in a particular part of your body, if you have stress or depression or anxiety or anything else it's mental illness because it's to do with your brain.*

In the above extract, positioning himself in this way in relation to MI serves to alleviate responsibility ('its not something you can make happen', 'there's nothing you can do to manage it'). Rather than construct MI as a reaction to life stressors then, Sergei offered a perspective characterising it as physical in nature ('to do with your brain'). He thus positions the sufferer as helpless in the face of MI as well as distancing MI from everyday life. If masculinity is

constructed as about power, in placing MI beyond the control of the men experiencing it, this leaves masculinity unchallenged.

This construction can therefore be regarded as a way to preserve power relations. Traditionally men have been depicted as the “strong” ones of the human species, the hunter -gatherers, and the breadwinners, responsible for the family/government/society. Notice the focus on responsibility and it’s role in constructing the “strong” image of masculinity.

Such constructions serve to maintain masculinity, that is, there is not anything that a man can reasonably be expected to do to protect himself against the onslaught of MI. It is not his fault; it is out of his control. What happens to the brain is beyond the coping strategies of any man.

Discourses were used to distance speakers from the notion of a MI as a response to a life event, thus detaching MI from something that has happened outside of the individual (factual/ life-event/ stress). To accept the influence of something factual on MH/MI/disorder could mean that accountability resides within the person. This lack of accountability is evident in the following extract:

Extract 2

Sergei: [...] I think like that [MI] is a chemical imbalance in your brain and things like that, there’s nothing you can do as an individual you know, you can’t make yourself better.

Some discourses also served to distance speakers from the possibility of experiencing MI themselves by constructing the “other” as the sufferer of a MI. These discourses therefore allowed men to preserve masculine ideas of ‘coping’ and strength as the default, natural way to be. By constructing MI as a biological error or anomaly, men were able to safeguard their sense of masculinity. This is evident in Extract 3:

Extract 3

Dean: [...] my dad is a man's man, I never saw him cry at all, and he's on hormone treatment for his cancer at the moment and my mom said he got up the other morning and he burst into tears: 'I don't want to die' [...] I was getting really worried thinking god he must be churning up inside and it's starting to come out because my dad never cries about nothing, real kind of don't do it and someone said to me the other day - it's the hormones, like a pregnant woman [...] so yeah my dad don't cry unless he's on hormone therapy.

Here coping with difficulties is constructed as intrinsic to masculinity. Dean's father is 'a man's man', suggesting that he exemplifies the characteristics of traditional masculinity. For example, '[he] never cries about nothing [anything]'. His emotional outbursts are therefore explained away as 'hormonal, like a pregnant woman'. They are constructed as a biological (rather than emotional) response and thereby they cannot threaten his son's (nor his father's or his mother's) constructions of masculinity, since they are

beyond his control. His crying is no more his fault, or under his control, than are the rampant emotions of a pregnant woman. The open expression of emotion, or even the possibility of MI, is deemed beyond the volition of the individual, in opposition to his usual strict adherence to the tenets of masculinity, and so traditional constructions of masculinity remain unchallenged.

Edley (2001, p.201) suggests that in looking at how '[men] talk about men and masculinity, we begin to understand the kinds of limitations that exist for the construction of self and others'. In the above extracts, it becomes apparent that there are limitations to the expression of emotion within traditional masculine constructions. MH and MI emerge as gendered constructs, framed within constructions of masculinity.

B: Machismo and biology

Participants tended to extend the naturalness of biological characteristics to include gendered traits, behaviours and interests. An example can be seen in Extract 4:

Extract 4

***Interviewer:** what do you think masculinity is?*

***Jason:** like being a man? Obviously being strong, strong-willed, taking care of the difficult problems [...] I suppose having a front where for example you won't be seen, be easily hurt, obviously working, football [...] I wonder whether part of it [...] must be natural, like in the genes kind*

of thing, like DNA, part of it must be, it can't be helped it must be inside, obviously not to the extent you shouldn't be able to talk if you're male, but I mean males generally like going out playing football, so part of it must be inside you, part of it can't be helped.

Here masculinity itself is constructed as biological, 'it must be natural like in the genes kind of thing, like DNA' and so 'can't be helped'. However interests such as 'football', traits such as 'being strong, strong-willed', and abilities such as 'taking care of difficult problems' are also characterised as innate. Masculinity is thereby constituted by, not only a collection of biological traits, but as consisting of a set of gendered qualities. These customary routinised discourses have been termed under the umbrella of 'macho' or machismo. In this way masculinity emerged as constructed as natural and fixed, with the expression of emotion as constructed within these terms:

Extract 5

Joshua: [...] *like being macho*

Interviewer: *what does that mean to be macho?*

Joshua: *I dunno, just 'give it the large' when going out, like we all play football and stuff like that, in that type of environment they feel, they can't really, I dunno, show their feelings.*

Above Joshua constructs men's behaviours, like playing football, as being in conjunction with (and as innate as) not showing feelings. Being macho

therefore consists of a whole set of accepted gendered behaviours that extend beyond the physical, but are inextricably linked to it.

Macho constructs were further routinised and naturalised (Edley, 2001), made innate and unchanging, by setting them against traditionally feminine ones. In the extract below, Sergei is being asked whether men and women deal differently with their problems.

Extract 6

Sergei: [...] maybe it's a hormonal thing, maybe it's genuinely a kind of gender issue, maybe there is something - you know - biochemical, [...] maybe there is fundamentally different in the way that men and women would deal with these issues

Interviewer: what you say is very interesting, being a man means you cope differently?

Sergei: yeah I mean you're expected to be, I guess it's genetic, I mean going back to kind of cavemen days the male was the provider, the male was the protector, you know, hundreds of thousands of years of genetic programming, it's kind of hard to overcome with any amount of good PR [laughter] but I think instinctively, maybe genetically programmed over hundreds of years of evolution, men are protectors, that's kind of the way that it's always been, and I think that's always going to be the instinct.

The extract puts in evidence talk of the '[fundamental] difference' in the ways in which men and women cope with emotion. It does so by conflating evolution and biology ('hormonal', 'biochemical', 'genetic', 'instinct') with 'a kind of gender issue'. In this way, gendered behaviours around mental distress are naturalised, and traditionally masculine discourses are preserved. This is further evidenced below:

Extract 7

Edward: *because women are completely different animals, its true [.] women aren't generally that good at that, they show their emotions too much, guys just switch on and off*

Michael: *yeah*

Edward: *one minute he can be acting like something in one room, he can walk out and be a completely different person in the next, that's what guys do.*

It is almost unimaginable what could serve to construct men and women as more fundamentally unlike than appealing to them as 'completely different animals'. In the above focus-group extract, women's emotional coping strategies are set against men's, and found wanting (women 'aren't generally that good at [coping], they show their emotions too much').

Men's tendency to 'switch on and off' is therefore deemed to be functionally superior. This discourse suggests that men's emotional expression is more adaptable. It constructs the ability to be able to 'switch [emotions] on and off'

as superior to emotional expression. This could set up a precedent for the rejection of emotional expression as legitimate expression of mental distress, and therefore the avoidance of HSB and MHS (Kingerlee, 2011).

Threats to Masculinity

Discourses that constructed *Threats to Masculinity* were very prevalent and presented in a number of ways. These are introduced here and then discussed below. Firstly, participants' talk about showing feelings was characterised as evidence of weakness. Showing feelings therefore was talked about as threatening to traditional understandings of masculinity, and were countered using images of strength and coping. Further, MHS as purveyors of help, were deemed as threatening to traditional masculinity. Since constructions of masculinity also conventionally involve control, where men described themselves as able to rationalise and therefore deal with problems, giving over control to MHS, was constructed as potentially daunting. Sergei, dealt this with for example, by describing men's typical coping style in mechanistic terms. This set it up in contrast to the emotive and experiential nature of therapy. Also, the somewhat amorphous, unknowable nature of MI was seen as a challenge to traditional masculine constructions. Furthermore, given the potential for 'threats to masculinity' that talk around MI and MHS evoked, humour and stigma were deployed as techniques to veto unwanted thoughts and behaviours. *Threats to Masculinity* will be presented in more detail below:

A: Showing feelings is showing weakness

As described above, men constructed behaviours such as serving as the 'protector' or playing football as being as much a part of masculinity as the ways in which emotions were dealt with. This functioned to inextricably link masculinity with strength and with unexpressed emotion, and to gender how MH and MI are understood. Therefore for the participants, behaviours that potentially threatened these constructions, potentially threatened masculinity.

Questions about their MH therefore generated some distinctive repetitive patterns regarding the link between masculinity and MH (Edley, 2001). If an important part of being male depends upon not showing feelings, constructions that encourage men to flaunt this, threaten their sense of themselves as male. Using MHS or even admitting to experiencing emotional difficulties to a GP was thus constructed as anathema to masculinity. For example, in describing emotional distress as 'for a bloke, it's a sign of weakness', Dean's construction was typical of how men talked about the sanctions governing their own and others MH-related behaviours. The notion that any form of admitting to finding a life event difficult to 'cope' with (and therefore requesting professional help) was a sign of weakness, and therefore a failure of masculinity, was a common theme throughout. The gendered nature of this construction is evident in the extract below:

Extract 8

Sergei: *I think in general men are a lot more resistant [...] to accepting that they have any kind of mental illness. It's the age old thing isn't it,*

that men are supposed to be strong, you know it's a sign of weakness? [...] you know if a man was suffering from a medical stress, [...] just like having a bad day but having a medically diagnosable condition of stress or anxiety, it would be seen as a weakness and you know the whole alpha male instinct kicks in at that point and men don't generally want to be seen as being weak [...] I think the biggest effect that would have is to kind of blinkered kind of non-acceptance of the condition, obviously that has a knock on effect in the treatment, I think it would take a lot more, not myself, but a lot of the guys I know, I think it would take a LOT for them to even go to the doctor. I think even at that point when they went to the doctor, I think they would be far more resistant to treatment, to accepting that there was a problem [...]

Interviewer: *and why do you think that is?*

Sergei: *it's that whole alpha-male thing [...] there's that expectation for men to be strong, powerful and whatever else, any sign of weakness, any chink in the armour is not good, it's unfortunate.*

Interviewer: *what do you think it is about talking to somebody that makes men think that they're weak?*

Sergei: *ahhh, its not being able to deal with the situation on your own, [...] you sort it out yourself you don't need somebody else to help you do it*

Interviewer: *and if you do need them, then it means you're weak?*

Sergei: *yeah, exactly.*

To characterise 'stress or anxiety' as 'weakness' serves to construct it as a threat to masculinity. Rather than seek help as a response, 'the whole alpha-male instinct kicks in'. Here Sergei resorts to biological explanations for gendered behaviour, constructing HSB as fixed and unchangeable. Stress and anxiety are therefore characterised as outside the acceptable experience of the typical male. This is a powerful factor in preventing men from seeking therapeutic input when they need it. Below this masculine coping style is reframed as positive, and termed 'resilience'.

Extract 9

Sebastian: *Not to show your emotion [...] it's just, just to*

Edward: *get on with it*

Sebastian: *yeah, just don't be, don't be weak really*

Michael: *yeah, well the thing is you just deal with it, that's what*

Interviewer: *what does it mean not to be weak?*

Michael: *well coz emotions is all crying over it*

Edward: *don't be crying all over it*

Sebastian: *not be unnecessarily emotional, yeah, be resilient, don't get, don't be defeated if you get knocked back or something.*

In both the focus-group discussion and the interviews, distress was constructed in negative terms (being 'unnecessarily emotional', 'knocked back' and 'defeated'). These terms chime with being 'weak' and challenge masculine constructions of overcoming problems/issues/challenges without emotionality. Experiencing distress, and potentially MI, was thereby

constructed as evidence of not coping and therefore as a failure to masculinity. Men should not only experience negative emotions and then be 'resilient' alone, but should rather not experience negative emotions at all. Crying for example, arguably an indication of emotional distress, was constructed as a female trait and generally rejected. When men cried, i.e.: experienced distress, it was frequently constructed as 'awkward', 'weak' and therefore un-masculine. The following extract is evidence of this:

Extract 10

Interviewer: [...] what does that feel like [to cry in front of your mates]?

Joshua: [...] I suppose it felt weird [...] your mates don't really see you like that. When you see your mates you're all happy, joking about, [...] to be honest I don't feel comfortable showing when I'm upset but I suppose a lot of men don't like [that]

Interviewer: why do you think that is?

Joshua: I dunno [...] they think you're weak or something like that.

The reaction of his peers forces Joshua to construct crying as inextricably linked with weakness. Below, he demonstrates the typical resultant construction in describing crying as a feminine response. This highlights its pejorative status. Again distress is rejected in the self and in others.

Extract 11

Joshua: umm its just women, they show their feelings don't they? It's easier to show, women will [cry], females will be more understanding about it, than a man.

The extract above describes how crying, the outward expression of distress, is better received in and by women, than men. Whereas in women distress is evidence of normal feminine conduct, in men it is a failure of masculinity. The public performance nature of traditional masculinity (Edley, 2001) means that when men cry in public spaces, this is characterised as not the norm, as 'weird'.

B: Mental health services are a threat to masculinity

Men's talk described maintaining the perception of masculinity (to themselves and to others) as being preferable to expressing feelings or seeking personal or professional help to deal with distress. This suggests that the use of MHS poses a threat to traditional masculine constructions and gives some reasoning as to why the use of primary MHS might generally be shunned by men (Clark *et al.*, 2008).

Extract 12

Interviewer: and would men see their GP or a psychologist about their problems?

Colm: *I'd say a lot of people my age and you know, being male, I don't think they would access [mental health services], they'd be, see themselves as weak if they do access that support.*

Talking to a GP or other health professional about MH concerns was generally constructed as not an option for men who bought into traditional masculinity. To many men then, MHS were deemed inaccessible and abandoned in favour of coping alone, to their own detriment.

Extract 13

Interviewer: *so do you think men should go to their GP if they have depression?*

Dean: *I think they should but I don't think they will*

Interviewer: *Why do you say that?*

Dean: *That's the thing, you just deal with it [...] I dunno, it's that old fashioned thing, be a man, deal with it, just deal with it, I'm so guilty of it, as I said you know that guy that split up with his girlfriend [I thought just] deal with it, go and get another one, stop being such a pussy.*

In the above extract, Dean is at the same time subject to a constraining discourse on masculinity ('be a man, just deal with it', 'stop being such a pussy'), but also wishes that men were not subject to that discourse and would seek help when needed ('I think they should but I don't think they will'). He is concerned that rather than distress being of primary importance to men,

it is the maintenance of masculinity that supersedes it and determines their HSB. Attempts to ask for help came with health warnings:

Extract 14

Interviewer: *would you ever go the GP if you had a personal problem?*

Edward: *never, no*

Interviewer: *do you guys all feel that way?*

Douglas: *no, my father did and he felt like it was a waste of time, he just felt like they was ridiculing him the whole time [...]*

Michael: *the doctor for me would be the last line of defense*

Edward: *exactly*

In the above extract the GP surgery was constructed as a place where you are 'ridiculed' and therefore 'the last line of defense'. Continuing the battle metaphor, outward expressions of distress are characterised as something that must be *fought against*. Only as a last resort could outside help be sought, and this was 'a waste of time'. Help-seeking for psychological problems was therefore constructed negatively, and deemed to be useless. Men's perceptions of seeking help from a psychologist were constructed as similarly unhelpful, as is evidenced in the following quote:

Extract 15

Interviewer: *What would stop men from going to see a psychologist?*

Sergei: *I think it's just it's this preconception [...] the biggest problem with men in general is this feeling that they should be able to do things themselves.*

Here it is implied that HSB is thwarted since men 'should be able to do things themselves'. Talking to a psychologist, represented as a failure in the traditional male coping style, is recognised as a 'problem'. Below, Colm suggests that the dilemma that men face is that such help-seeking is in fact 'shameful':

Extract 16

Colm: *I think it's probably about shame really, [...] a lot of men would think its quite shameful to access help from you know a doctor or a psychologist, to get help with their mental health, and they might be - I just need to deal with it, I need to sort it out myself [...] I think its kind of shameful for a lot of men to be seen as you know being mentally unstable in any way for whatever, whether it be depression or anything else.*

The shame of experiencing mental distress is compounded if men seek professional help. Even in the face of MH professionals, men need to be seen to be '[dealing] with it' to be deemed to be conforming to traditional

masculinity. Men are in a difficult position because any attempt at HSB is thus an unacceptable threat to their construction of themselves.

C: Mental illness is unknowable

MI was sometimes categorised as being different from physical illness. Physical illness was constructed as concrete and therefore treatable with medication, whereas MI could be more nebulous and harder to treat.

Extract 17

***Interviewer:** and do you think [mental illness] is the same/ different to physical illness?*

***Jeremy:** oh yes definitely different, I suppose with physical illness you can pinpoint the problem, and take like anti-biotics, like to sort it out, but when its mental, it's in your head isn't it, you can't just get inside your head and pull it out can you, you have to like come to terms and stuff and like, I dunno like get over it, you can't just take something and it will go away.*

The amorphous nature of treating MI made it more threatening. The inability to 'just take something' presents MI as more evasive than physical illness. In the extracts below developing MI is further characterised as insidious since the 'line' between MH and MI is frequently constructed as unknowable.

Extract 18

Sergei: [...] *I don't know where to draw the line between sort of stress and the natural, as I say, having a bad day, having a tough time and having a mental health issue.*

Extract 19

Dean: *but depression, I don't know what depression is? How do you know you're depressed? Everyone has bad days, I don't know what that means.*

MI was therefore deemed ominous because it was constructed as being incomprehensible to differentiate from typical difficulties (which traditional masculinity should be able to defend against). Within the focus-group, it was seen as so ambivalent that 'you wouldn't even know that you've got a problem'. MI therefore emerged as a threat to masculinity as it could not be fully understood nor controlled by easy categorisation or traditionally pragmatic masculine coping strategies. Also, the need to maintain masculinity superseded seeking help for MI. MHS served to personify this dilemma.

D: Vetoing behaviour

Threats to masculinity were vetoed in various ways. Attempts to construct masculinity in alternative ways was most commonly met with humour and with derision. Humour was often characterised as being designed to stigmatise and shame unwanted behaviour in others:

Extract 20

Dean: *you see in my circle of friends, [crying is] really not allowed, I cried a few times in the pub, when I've been a bit drunk and emotional and they're like, oh shut up, sort of smack you on the head*

Interviewer: *so they stop it?*

Dean: *yeah, stop it, don't do it, don't wanna see it, stop it*

Interviewer: *how do they stop it?*

Dean: *yeah, sort of make a joke of it, or shut you up, or you're being silly and then you do try and stifle it because you think I'm making a right fool of myself [...]*

Interviewer: *so they feel its not appropriate*

Dean: *kind of, that's not the way a man is supposed to deal with things, you know, my mates are blokes blokes, you never see them cry, that's frowned upon [...] they think emotions is a sign of weakness.*

Dean recognises that his 'mates' characterise emotional displays as being a sign of 'weakness' and therefore as unmanly and inappropriate. Should he fail to, they respond quickly by using humour to 'stifle' unwanted behaviours and 'shut [him] up'. This peer reaction is mirrored in the extract below where Joshua is subject to the same sanction by having 'the mick' taken out of him. This policing of the bounds of behaviour is a form of 'bullying'.

Extract 21

Interviewer: and is that what stops you going to ask for help?

Joshua: yeah, or you're worried about the reaction, or if someone finds out that they're talking to so and so

Interviewer: what would the reaction be?

Jason: ummm I think it depends who it is. Like if it was your mate he would really like in the playground, like taking the mick, or like bullying, like everyone talking about it, what a weirdo, that kind of thing.

Avoiding being seen as different, a 'weirdo', was evident throughout men's talk, from the playground to the pub. Afraid of having the 'piss' taken out of them, humour acted as an effective behaviour-shaping technique, even in the absence of direct sanctioning.

Fear of shame therefore led men to self-sanction their HSB. Men were aware that if they expressed negative emotions, such as sadness or fear, they would be teased and shamed. Shame also functioned to veto others' behaviour when that behaviour was deemed incompatible with traditional masculine values. Seemingly playful joking and laughter therefore acted as a means of restriction. In sanctioning others, traditional forms of masculinity are maintained in the self and in others. The impact of masculine vetoing is evident in the following extracts:

Extract 22

Joshua: *yeah, yeah, I suppose a lot of times if people will take the piss out of them, ahhh, they shut up. Stop being a wuss and all that*

Interviewer: *what will men say if you show your feelings?*

Joshua: *Umm, like shut up [...] yeah I don't think they'll want to talk about it, they'll avoid the issue and stuff [.] I dunno I suppose they just keep [their feelings] inside.*

Extract 23

Jason: *[they'd] take the mick, especially if they're tryna open up to you about something and it gets thrown back, they're never gonna open up again coz they'd be scared it would get thrown back again [...]*

Interviewer: *aha*

Jason: *I think it's coz like everyone looks at it like that so it's automatically drummed into men that they shouldn't show their feelings or its unmanly [...] like you wouldn't go down the pub with your mates and talk about your feelings, you'd talk about the football kind of thing [...] say you're with a group of men, none of you want to be seen like, if you're with a group of men and one of you was like oh I'm feeling so and so, everyone would look at you like you're a bit weird kind of thing, if you just talk about your feelings in front of the other lads.*

In both extracts, being stigmatised and shamed (having the 'mick' taken, feeling a 'bit weird'), acted as an effective means of learning and maintaining traditional masculine role behaviour.

These unspoken rules of masculinity extend to attempts at accessing MHS, where men frequently mentioned that stigma was associated both with taking medication for MI and with seeking help from psychologists.

Extract 24

Interviewer: *what would your friends say if they found out you were seeing a psychologist*

Joshua: *umm they'd obviously ask why and then see it as a bit weird, what you on about? They probably wouldn't understand why you needed to talk to someone, then they'd probably tell other people*

Interviewer: *and what would happen then?*

Joshua: *then you'd have this thing that everyone's talking about you*

Interviewer: *so that kind of thing would stop people going [to a psychologist]?*

Joshua: *yeah.*

E: Legitimacy

Despite attempts to maintain their constructions of MI as outside of traditional masculinity, there were certain life situations in which men gave psychological distress clemency. Clemency was granted if situations were deemed of significant severity. Examples involving unexpected death, particularly of a child, were frequently mentioned. Tragedies such as these were not considered as challenging men's construction of themselves as being able to cope because the events were deemed to be of sufficient gravity to warrant

open distress. Men were therefore given tacit permission to express emotion without posing a challenge to their own or other men's constructions of acceptable masculine behaviour, as long as the behaviour was context-dependent and time-limited.

Extract 25

Edward: *yeah well that's what I mean- when Seb said if your kid died or something then obviously that wouldn't be shameful, but I think people would think if you just got it [depression], for no reason, it was actual chemical imbalance, you'd think why am I feeling like this? I feel weak and all that and I can't go out you'd feel it but you wouldn't know why you had it. At least that way you could say to yourself I know why I'm depressed - this is acceptable coz my kids died or [.]*

Edward: *yeah*

Sebastian: *but if you just had it for no reason you'd be ummm, at our age you shouldn't be like that, you should be happy go lucky, going out drinking.*

Here members of the focus-group are suggesting that it is legitimate for a man to become depressed only if he has had experienced something that is easily identifiable and sufficiently traumatic. In the absence of such legitimacy, the presentation of depression was deemed confusing, and was no longer seen as 'acceptable'. In such instances depression resulted in shame and self-criticism and a belief that 'you shouldn't be like that'.

Below Douglas suggests that men adopt a kind of barometer that determines the severity of the event, and thereby legitimises or invalidates the experience of mental distress.

Extract 26

Douglas: [...] we kind of scale things, we look at stuff everyday and we determine that to be a high or a low

Interviewer: in terms of emotion?

Douglas: yeah if it's really really high we would probably talk to each other

Edward: yeah

Douglas: if it's low we just switch off and carry on

Edward: blokes are very good at turning off their feelings.

Douglas, it seemed, uses a subjective 'scale' of 'high' or 'low' to determine what is sufficiently serious to challenge masculine constructions of coping. This suggests that there was an implicit agreement amongst his group of men about how serious something has to be before they can legitimately claim support from one another. This barometer may not correlate with that of MH professionals and services.

Extract 27

Dean: if your two-year-old son has been killed, I think you need to speak to someone, or something traumatic like that, [...] but to go to

therapy because of something as trivial as a partner's left you or you are a bit down [shakes head].

Dean agreed that the breakup of a casual relationship is not a valid reason for seeking psychological support, and that this (and other similar difficulties) should be 'bottled up' and borne as part of traditional masculine behaviour.

MI and MHS were thus talked about within the framework of *Masculinity and Threats to masculinity*. The contrast between these two IRs made certain ideological dilemmas available. These will be discussed next.

Ideological dilemmas (IDs)

In this section, the IDs and interactional consequences of the IRs discussed above will be examined. It will be argued that much of the ideological thrust of men's discourses on MH is carried by the ways that the two IRs of typical and non-typical man are worked together, and in the rhetorical relations about MI that this allows. The regular and routine ways in which the IRs were used together and the consequences of that use will be examined.

Analysis of the text revealed four IDs:

- I'm not a typical male
- Mental illness is categorical/ on a continuum
- Mental health services threaten/ support constructions of masculinity
- As a man, if I have everything, how can I be depressed?

Within each dilemma exists an inherent friction between two or more commonly held positions (Edley, 2001) suggesting that neither construction exists without its opposite or corollary. Furthermore there exists an interplay between the opposing constructions of masculinity and the ways that this impacts on constructions of MI and on MHS. These will be explained in more detail here:

A: I'm not a typical male

Being in a position of admitting to experiencing MH problems is in itself an example of an ID. That is, acknowledging difficulties in emotional coping challenges culturally held assumptions of traditional masculinity.

It has already been established that talk about traditional masculinity and its behavioural characteristics was ubiquitous in the data. In order to reconcile the seemingly irreconcilable poles of conforming to traditional masculinity with still being sensitive, emotional men who were willing to discuss feelings and MH within the context of this research, nearly all men described themselves as not typically male:

Extract 1

Dean: [men] just deal with stuff and move on, which I'm not, I'm not a man's man.

Extract 2

Joshua: *to be honest I'm not too bothered about trying to be a macho man, and stuff like that. I can be quite open about how I feel. Other men don't show their feelings, but I do.*

These extracts suggest that rather than rejecting the established constructions linking traditional masculinity and mental distress, the dilemma was dealt with in an ingenious way. These extracts are just two of many that position men in the interviews as being different to other men ('I'm not a man's man'). Positioning themselves thus allowed participants to 'be quite open about how [they] feel' in the context of the research, while still maintaining traditional masculine behaviours and approaches to MI and MH.

Implicit in this new construction is a criticism of conventional 'macho' behaviours. Elsewhere however it was evident that men still conformed to these stereotypes, particularly in public. This dichotomous construction of masculinity is particularly evident in the close-knit focus-group, where men offered each other support in both traditional and non-traditional masculine behaviours. In this way traditional masculinity was both challenged and maintained through group constructions.

Extract 3

Michael: *this group that we have I think it's a different group to what a lot of people have*

Edward: *yeah a lot of people say that to me*

Michael: *coz we went on mine and Gerard's stag dos, people were surprised because normally with stag do it's people's work mates, families, stuff like that whereas we've been friends for years because we live in the same small village and everyone lives here so this is a bit of a, well its unusual, well it's different to what it normally is because I can just walk down the road see anyone, go down the pub, the club we can talk to each other, so we've got a lot more support, man time, if you know what I mean, and you don't even have to talk about stuff, just men who sit down [...] you don't have to talk about how you feel, it's just talking in general. If you're feeling a bit down you don't even have to talk about it, just the fact that you are talking to someone you've known for a long time [helps].*

Not only did each man in the individual interviews position himself as not being a typical man, but the friendship group that constituted the focus-group was also characterised as a 'different group to what a lot of people have'. In contrast to how other men's friendship groups were constructed, this group 'can talk to each other, so we've got a lot more support', however this support was still constructed within particular gender limits, and termed 'man time'.

The contradictory construction - that participants were somehow different to typical men - acted perhaps as a means of allowing men to cope with the contradiction posed by this ID. Presented with constraining messages about masculinity but experiencing distress nonetheless, participants had developed

an alternative identity. This extended also to their construction of HSBs, as is evidenced in the following characteristic extract:

Extract 4

Interviewer: [...] do you think that if you weren't feeling mentally well you might visit your GP and tell them?

Colm: I mean personally I would, but I have lots of friends who I think they are more working-class man, they wouldn't go to a GP, they'd just kind of deal with it, you know, I'm a working-class man, I don't need help you know, ummm, I dunno just bottle it up [...] but personally ummm I'd have no problems going to see a GP if I was feeling unable to cope in any way, umm, seeking support for, in ways that could help me, um, but I'd say a lot of people my age, you know, being male, I don't think they would access it, they'd see themselves as weak if they do access that support.

Rather than challenge his own notions about others' private HSBs, Colm is claiming that he is alone in thinking he might seek help while others would not. Elsewhere Sergei constructs himself as 'very open', 'willing to talk about things' and 'very openly emotional, very sensitive'. These constructions were evident in *all participants* talk and have arisen in relation (and opposition) to traditional constructions of men as closed and unemotional (Edley, 2001). However men were not able to use their own experiences to challenge their constructions of others' masculinity and HSB. As a result, traditional constructions of men's HSB are maintained publicly, while still being

challenged by participants within themselves. The silence and stigma surrounding talking openly of these contests to identity prevents traditional attitudes to MH, MI and MHS being publicly challenged.

These contradictory and inconsistent constructions of masculine behaviour point to the fragmentary beliefs, values and practices coexisting around MH (Edley, 2001, p.203). This leaves men with an ID between two poles that are both constructed in relation to traditional masculinity, whether in support of or opposition to it.

B: Mental illness is categorical / on a continuum

MI was constructed in a number of ways. On the one hand it was constructed as on a continuum within ordinary human experience, whereby there was no obvious break between everyday coping and MI. This served to normalise MI, though it made it more threatening, since the line could more easily be crossed.

Extract 5

Sergei: [...] Mental illness is not something you ever you know, you never really get taught in terms of what is just having a bad day and what is depression and what is you know where do you draw the line between sort of stress and the natural, as I say, having a bad day, having a tough time and having a mental health issue?

In the above (typical) example, Sergei characterised depression as something more than 'just having a bad day', but the distinction between the two is 'difficult' to distinguish. Here MI is on a (rather frightening) continuum with everyday experience.

The ID emerged when participants referred to people with MI. Rather than being on a continuum with "normal" experience, this construction of MI places it within a separate category altogether. In the extract below for example, Dean described people with MH concerns as 'not right in the head', suffering from a 'disease' and therefore as being 'not normal'.

Extract 6

Dean: mental illness issues, I mean that's a tricky one, the horrible thing I would say is anyone who is not right in the head [...] because it could be a disease [...] they're mental, it's someone whose got issues or problems?

Interviewer: what do you mean?

Dean: I don't know, just someone who isn't normal.

This pole of the ID placed people with MH concerns at a distance ('it's a disease', they aren't 'normal'). Potentially this serves to protect men from their fear of developing MH concerns (which the first pole allows for). The effect of placing MI both within a category that is continuous ('where do you draw the line?') and one that is categorical ('it's a chemical imbalance') is an example of how 'tensions and contradictions' exist within the ways in which MI is talked

about (Edley, 2001, p.203). Here, the ID of how to categorise MI overlaps with the IR of MI as being unknowable. Edley (2001) argues that there are commonalities between the two analytical tools. This dilemma marks a larger debate around an attempt to destigmatise MI on the one hand, in the face of fear and ignorance about its nature and impact on constructions of masculinity on the other.

C: Mental health services threaten/ support constructions of masculinity

As established, since openly experiencing negative emotion and consequently seeking help was frequently constructed as a sign of 'weakness', accessing MHS was seen as a threat to masculinity. This can be seen below:

Extract 7

Sergei: mental [illness], you know if a man was suffering from a [...] medically diagnosable condition of stress or anxiety, it would be seen as a weakness and you know the whole alpha-male instinct kicks in at that point and men don't generally want to be, be seen as being weak and I think in the first instance I think the biggest effect that would have is to kind of blinkered kind of non-acceptance of the condition, obviously that has a knock on effect in the treatment, I think it would take a lot more, not myself, but a lot of the guys I know, I think it would take a LOT for them to even go to the doctor. I think even at that point when they went to the doctor, I think they would be far more resistant to treatment, to accepting that there was a problem.

In this extract, Sergei constructed 'having a medically diagnosable condition of stress or anxiety' as a 'weakness' and therefore seeking assistance from a doctor for a MH concern as 'a chink in the armour'. In this fighting metaphor, help-seeking for MI is not what 'alpha-males' do; instead they deal with their problems on their own. The implication is that MHS remain under-utilised because their very nature threatens traditional masculinity.

On the other hand, MHS provision were characterised as a feminised activity, often staffed by female psychologists, and therapy structured as a feminine HSB.

Extract 8

Interviewer: *would a man see a psychologist?*

Colm: *definitely girls and women find it easier to discuss their problems and get upset and get things off their chest and I think it seems if you're a boy or an adult male umm it would seem a bit weak if you know you cry or get upset or discuss your problems and I think it is easier umm as a female to talk about your issues.*

In this way, services could be seen to implicitly support traditional masculinity. Their feminised construction, whereby you 'discuss your problems, places services in opposition to traditional masculinity, thereby maintaining traditional gender divisions.

The idea that women access MHS more than men was a frequent pattern of discussion, as was the talk about female therapists not being able to 'relate' to male concerns. This resulted in constructions around who typically uses MHS:

Extract 9

Colm: well obviously mental health services are open to everybody but women access mental health [services] more than males I would say.

This extract points to a construction that serves to further entrench the gendered nature of services. Within traditional women's behaviour, help-seeking therefore continues to be regarded as innate, acceptable and thereby normalised. This ID therefore resulted in widening the gap between those who could legitimately use MHS and those who could not. Since MHS were seen to cater to the female mind-set, they were seen as maintaining the dichotomy between men's and women's coping styles, and thereby as tacitly supporting traditional constructions of masculinity.

D: As a man, if I have everything, how can I be depressed?

This ID was seen as stemming from participants' confusion around having achieved the milestones of traditional masculinity – marriage, work, children – yet still feeling unfulfilled. In the (typical) extract below for example, Colm cannot fathom how someone whom he knew who 'had everything' could have committed suicide:

Extract 10

Colm: you might have a house, a family so everybody's umm thought of is you've got it all, so why, why you unwell, why are you, why do you feel down, what is it that's making you feel down, you've got all this? Yeah I think that it's really because people tend to think you know, if you've got everything you need, such as umm a home, a family or a girlfriend or umm a job that you're umm comfortable with, then what else can go wrong?

In this way, MI is again deemed confusing and a challenge to hegemonic masculinity (Courtenay, 2000). It is threatening in that it is seen to arise despite the achievements of traditional masculinity, where attaining stipulated goals should guarantee happiness and preclude MI. This ID seems to imply that MI is extrinsic and that once certain goals are achieved, mental wellbeing should be guaranteed. It also suggests that accessing MHS is acknowledgment of the failure of masculinity. Potentially threatening questions about masculinity are raised. These questions pose opportunities for different subject positions, discussed below.

Subject Positions (SPs)

To finalise this section, further analysis on how men positioned themselves in relation to the IDs and IRs is presented in the form of SPs.

The two IRs of Masculinity and Threats to Masculinity presented above suggest that men were talked about in two broad categories, typical and non-

typical, according to their attitudes to MI. In practice, men's accounts of MI moved backwards and forwards across the discursive field these two IRs establish, often through the process of discussing and arguing. The typical and non-typical types of men were analysed in more detail, suggesting four main SPs:

- Traditional machismo
- Challenge to machismo – I'm not a typical male
- He just isn't right in the head
- Part-timer

Though these SPs have already been alluded to within the IR and ID sections, they warrant some further discussion.

A: Traditional machismo

Analysis of the texts revealed the ubiquitous presence of the traditional male identity that eschews outward displays of distress and is not subject to MI in the form of depression or anxiety. Rather he personifies characteristics of bravery, strength and resilience. Above all he copes outwardly with the difficulties life throws at him by demonstrating the traditional characteristics of the 'alpha-male'. The traditional male will do everything he can to avoid admitting that he is subject to emotional weakness, even if this means not benefitting from the support of his friends or MHS.

In the extract below we see how Sergei's friend was occupying this position. He was receiving treatment for MH concerns, but this was kept private even within close friendships as it was subject to stigma:

Extract 1

Interviewer: *and why do you think he didn't tell you?*

Sergei: *it's the whole weakness thing, he was going through a really stressful time, he had three children and [his wife] died in a hospital operation [...] They were devastated, obviously, and you know it was a massive amount for him to deal with, but even under that situation where it would be perfectly understandable you know, he was still, I mean at least he actually went to get help, which is a good thing I guess, but he still didn't really want to [...] you know, show any signs of not being able to cope [...] but in terms of not telling anyone else, it's a tough one, I mean I wouldn't actually if I was on medication I wouldn't go out of my way to broadcast it to people for sure [...] you know the fact that he only came out with it six months later so, I think it's difficult because as I say there is this stereotype [...] there's a certain ideal image that is conveyed and that is, the you-know, strength and being able to, you-know, carry the weight of the world on your shoulders [...] I think it boils down to the difference between what is acceptable, I don't like the word, but you know, acceptable behaviour and what isn't [...] I think there's an element of pride [...] that you should be able to manage it yourself.*

As Edley (2001, p.210) suggests 'people are not always 'hailed' from afar, but ... 'it is quite possible to subjectify 'ourselves' within the contours of our own discourse'. It was evident in this and the other interviews that men were constrained both by social constructions of 'acceptable behaviour', but also through their own self-imposed limitations. Here Sergei is positioning himself and his friend as subject to the constraints of traditional machismo (being expected to 'carry the weight of the world on your shoulders'). They must occupy the roles of traditional men if they are to be 'acceptable' to other men, despite this being a burden. These limitations on identity extended to HSBs:

Extract 2

***Colm:** I think [my friends would] find it quite embarrassing, I don't think they'd ever tell me that they were seeing a psychologist or that they were accessing some kind of mental health support, you know, I think they would keep that bottled up [...] I think they'd see that as opening up too much and showing their weakness too much*

***Interviewer:** what is it about seeing a psychologist that is about showing weakness?*

***Colm:** I suppose to others it might seem that you know again that you're just a bit weak and you can't do it yourself.*

By not telling their friends that they are seeing a psychologist for example, Com describes how men perpetuate the notion that they are self-sufficient and do not require support from professionals. This traditional male SP was

almost universally normalised and was evident in many aspects of men's talk about their daily lives.

If men did experience distress, they tended to use appropriately masculine metaphors to describe these experiences, maintaining macho constructions. For example, Joshua described his suicidal thoughts by using a football metaphor 'I really thought I would take myself out the game'. In this way, mental distress is still framed within a male-typical identity.

B: Challenge to machismo – I'm not a typical male

This second subject position is known to the reader as one dichotomy within an ideological dilemma already discussed. Therefore it will not be discussed in much detail here.

Typical men, as we have seen, were positioned as demonstrating the ability to cope, for example never crying in public, and always guarding against experiencing distress openly. The atypical man however is someone who acknowledges mental distress and outwardly expresses emotion. Rather than challenge traditional constructions of masculinity, all interviewees constructed themselves as atypical, as unlike other men. In this way a new SP was developed alongside traditional masculinity.

Extract 3

Dean: that's the blokey thing again, I think. We don't [cry] we just deal with stuff and move on, which I'm not, I'm not a man's man [...] I like a cry and I do like a cuddle.

Unlike his friends, Dean is openly affectionate and seeks reassurance from them. He experiences his feelings more freely. By studying this quote and looking back at the quotes used earlier, a pattern emerges of an atypical man who accounts for himself as being different to his peers. This alternative identity is evidence of agency in identity formation. It was commonly raised by participants with an element of pride at being apparently able to resist conforming to a stereotypical identity. This SP offers a challenge to typical constructions of men's MI and MH and an opportunity for alternative views about MHS.

C: He just isn't right in the head

A third subject position that emerged in the data can be seen in the following two typical extracts involving constructions around MI:

Extract 4

Joshua: [my friends] probably think you go see a psychologist or a psychiatrist strapped up in a white jacket in the back of a van.

Extract 5

Dean: *[he's] in a funny farm, just nutted off [and] gone mad, yeah, or just not right in the head, [...] Something went wrong...*

This position constructs men who use MHS and who experience diagnosable MH concerns as another kind of man, as 'not being right in the head'. Their MH status means that they were 'not normal'. These men are relegated to a separate category, where their distress is explained by 'genetics', a 'chemical imbalance', 'oddness', and therefore they should be 'locked away in a padded cell'. The idea that MI is 'something you're born with' and that 'there's nothing you can do to manage it' (Joshua) serves to safely separate the men interviewed from men with MI. This SP concedes that men may not take up this position voluntarily.

D: Part-timer

This final subject position also emerged frequently in men's discourse. In this position, as in the SPs 'I'm not a typical male' and 'He just isn't right in the head', men were given a respite identity whereby the outward pretence at coping does not apply. However this SP potentially applies to all men.

Occupying this position, otherwise traditional men are given leeway to behave in non-traditional ways. Within this SP, they are no longer subject to the constraints of 'bottling up' their feelings. However the *Part-timer* only applies within certain socially sanctioned arenas, for example when drinking:

Extract 6

***Joshua:** well obviously alcohol and drugs [my mates] just get pissed and for five, ten minutes of being absolutely paraletic you're not trying to bottle it up [...] it's a release [...] if they are having trouble with their girlfriends and stuff, they just go drinking.*

In the above extract it is evident that alcohol is an important catalyst that provides for the emergence of an identity that is acceptably emotional and expressive. A man who takes up this position is provided with a 'release' for pent up emotion in the position of the drinking man. The drunken man is forgiven for both escaping his distress by drinking and for expressing his distress through drinking.

Other part-time identities were mentioned, including the sportsman and the fighter.

Extract 7

***Interviewer:** but guys might use alcohol to cope?*

***Joshua:** yeah I think so*

***Interviewer:** what else might they do?*

***Joshua:** we play football on the weekend [...] a few of my mates, and usually when they go out they're fighting as well, maybe they've got like feelings hyped up inside and they see that as a kind of release, fighting? Pretty normal really, nothing major.*

Extract 8

Sergei: [...] everyone has different ways of dealing with stuff I guess, some guys I know when they get stressed they go to the gym, they have an insane workout for a couple of hours and you know get the endorphins pumping to help it.

Certain contexts (the pub, gym, football field, the fight) thereby provided men with identities that were not subject to the usual constraints of traditional masculinity. Within this SP, men were allowed to express or channel emotion freely, and were forgiven even for showing 'weakness' or requesting help from their friends. Importantly, the *Part-timer* could exist alongside traditional masculine SPs without posing any threat to them.

The continuance of the traditional constraints of masculinity on MH and HSBs, despite the existence of 'free zones' such as the pub, however highlighted the power of traditional masculinities in relation to MH. The 'Part-timer' SP allows for the continued existence of the traditional male without the threat to masculinity implied by departing from these norms. It also provides an opportunity for the legitimate expression of mental distress, however over-reliance on externalising behaviours (drinking, fighting, exercising) can indicate MI in itself (Branney & White, 2010).

DISCUSSION

The way that men talk about mental health (MH), mental illness (MI) and mental health services (MHS) is likely to vary according to a range of factors including age, socio-economic status, sexuality, culture, ethnicity and geographical region. This study focused on how young white British men from working-class backgrounds in the South-East of England talk about MH, MI, MHS. Previous research suggests that this population is particularly susceptible to traditional masculine constructions and resultant reluctant help-seeking behaviours (O' Brien et al., 2005, NHS, 2009, Courtenay, 2009). Findings showed that men in this study constructed MI and MH in relation to discourses around traditional masculinities, and that this then informed how they constructed MHS. The discourses uncovered demonstrated how socio-economic, age and cultural factors were intrinsic in constructions of acceptable help-seeking behaviours in relation to MH.

As has been seen, men in this study constructed MH and MI under two interpretative repertoires (IRs): Masculinity and Threats to Masculinity. These apparently opposing IRs also shaped their descriptions of MHS and behaviours around help-seeking. Four ideological dilemmas (IDs) were uncovered that put into practice men's dilemmas regards negotiating their masculinity in the context of their MH. These IDs contain 'common sense notions' that allowed for, sometimes contradictory, discourses around MI and MHS to co-exist (Edley, 2001, p.217). Subject positions (SPs) are one way in

which these ideological dilemmas around MI, MH and MHS connect to wider social practices of power (Edley & Wetherell, 1999). Four SPs were identified. Men were able to switch between these depending on context, whether it was the gym, work, home, pub, interviews or focus-group (Edley, 2006). In this way, these SPs served to connect discourses and interpretative repertoires about MI and MHS 'to the social construction of particular selves' of traditional and non-traditional men (Edley, 2001, p.210). The way in which this occurred will be discussed in more detail next.

Firstly, amongst participants, emotion talk was repeatedly and almost uniformly used to describe weakness. In local British society where hegemonic constructions of men dominate, and where men are therefore deemed invulnerable (Courtenay, 2000), masculinity, MHS and MI were deemed anathema to one another. This resulted in men not presenting at MHS because services were constructed as places which one accesses when 'weak', and therefore challenge hegemonic constructions of masculinity.

Existing MHS therefore represented a threat to the carefully constructed elements of masculinity around which so much of participants' identity were built. This was in part related to class. In this way, just as masculinity had become 'routinised' (Edley, 2001), men's constructions of how they relate to MI and MHS were naturalised by being situated within these same gendered and classist discourses. Furthermore, in adopting negative attitudes and therefore behaviours in relation to MH and MHS, men were actively using these to reconstruct hegemonic masculinity.

Secondly, given men's troubled relationship with the expression of emotion (Edley, 2001), participants found understanding what constituted MI difficult. As a result, MI was constructed as something that happened to other men, allowing participants to negate the idea that it was on a continuum with ordinary human experience. It also legitimised the 'othering' of those suffering MI. The tendency to medicalise MI served to further distance the speakers from the chance of becoming mentally ill, thus maintaining the discourse that men are resilient and able to cope with distress (Courtenay, 2000). Furthermore, current treatment for MI was constructed as falling outside of the structured, logical remit that is traditional action-oriented masculine behaviour (Kingerlee, 2011), and therefore rejected. This allowed men to mobilise the discourses constituting traditional masculinity as perceived protection from the threat of MI.

Thirdly, the power of stigma and shame about MI in shaping others' non-conformist behaviour was revealed through the tactical use of humour and derision. The threat of rejection by peers was sufficient to force men to shape their own conduct according to notions of strength and resilience. 'Unacceptable' behaviour was vetoed, ensuring that both their own and other men were kept within the remit of hegemonic masculinity (Edley, 2001). This left little legitimate room for the consideration or experience of MI or the use of MHS services.

Fourth, men were given clemency to express emotional distress, but only within certain situations and contexts. These were either as responses to

certain serious life events (such as death), or within particular legitimised spaces (the pub, the sports field). Under these particular circumstances, hegemonic masculine constructions remained unchallenged. Walton *et al.* (2004) found similar discourses around permissible emotional expression within distinct contexts (football match, nightclub). Sanctioned contexts did not however include MHS, which were not legitimised since they were characterised as feminised spaces, representing vulnerability.

Fifth, men referred to an 'atypical' masculinity, but this was subsumed under a 'typical' hegemonic masculine identity. Participants oscillated between these SPs depending on whether discussion was around the pub, home, or within the context of the research, suggesting that masculinities are fluid (Edley, 2001) and contextually negotiated (Courtenay, 2000). Given the continued power of hegemonic constructions within contemporary British society, men found it easier to reject alternative identities in favour of dominant discourses around their masculinity. This impacted on their beliefs about MH and MI, which were also subject to hegemonic constructions. Traditional masculinities also superseded non-traditional masculinities in guiding the unspoken rules around the taking up of MHS.

Lastly, participants talked about medication as a somewhat more legitimate response to MI than talking therapies. This may in part have been an extension of their construction of MI as 'biological' and 'genetic', and another attempt to distance themselves from responsibility for/ threat of MI. It also

further elucidated why psychological interventions (of which IAPT forms a part) were not considered.

Links to Past Research

Help-seeking behaviour

This study offers validation for previous research, both qualitative and quantitative, into men's physical help seeking behavior (HSB) framed in relation to their constructions of masculinity. For example, men's constructions that help-seeking is associated with weakness and with traditionally feminine coping-styles has been the subject of previous research into physical health (eg. Addis & Mahalik, 2003). Courtenay (2000) has linked denial of weakness and rejecting help to masculinity and HSB. Furthermore, HSB has previously been found to be constructed in opposition to the traditional action-oriented male coping strategy (Helgersen, 1995). This study extends HSB and masculinity to apply to MH within the local context.

Furthermore, this study offers validation for previous research into constructions of masculinity preventing men from using MHS. For example the fear of ridicule and shame/ stigma has been found to be a powerful deterrent (Moller-Leimkuhler, 2002; Vogel, *et al.*, 2007). Previous findings have argued that entering therapy is seen as in 'direct conflict' with masculinity (eg. Mahalik *et al.*, 2003). Furthermore, the finding that men characterised their gendered upbringing and socialisation as restrictive of emotionality has previously been found to predict attitudes to psychotherapy (Tsan *et al.*, 2011).

Hegemonic masculinity and the non-typical male

Importantly, using a critical discursive psychology approach, this study offers support for the negative impact of hegemonic masculinity on men's MH. Hegemonic masculinity is a contextually-situated idealised form of masculinity (Connell, 1995) and its 'instruments' are often those that lead men to harmful behaviours, including denying pain, weakness, vulnerability, or need for help (Courtenay, 2000). This reinforces culturally held beliefs that 'men are more powerful and less vulnerable than women' (Courtenay, 2000, p. 1394), which sustains health inequalities, such as has been found in this study amongst working-class British men.

There is a well-formed body of literature (both qualitative and quantitative) that shows that men who embrace hegemonic forms of masculinity are more likely to engage in risky physical health behaviours than those without these beliefs (eg: Pleck *et al.*, 1994). This study found evidence for the presence of unhelpful behaviours linked with identity within MH amongst white working-class men from the south of England. Research has also previously linked lower socio-economic status with hegemonic masculinity and risky health behaviours (Courtenay, 2000). Furthermore, this study confirms previous research that suggests that whether or not men conform to masculine stereotypes - they may self-identify as 'atypical' - they are still measured against them (White, 2007). This means that in practice, participants all found themselves subject to the constraints of hegemonic masculinity. This shaped their constructions of MH and MI, and their approach to MHS.

Previous focus-group research has shown similar attitudes within men to the relationship between masculinity and MI. For example, O'Brien *et al.* (2005) found it difficult to 'penetrate the machismo' in discussions around depression with a sample of Scottish economically diverse men. Younger men too expressed particularly rigid views. Humour was also used, however in the O'Brien *et al.* study it functioned to move the discussion away from personal experiences of depression. In this study, humour acted somewhat less innocuously; as a veiled threat to elucidate changes in others' behaviour.

In order to understand men's attitudes to MI in other men, as well as the derision with which mental distress is greeted, it is useful to consider how the concept of hegemonic masculinity is maintained. We have seen that men will support an idealised version of masculinity, even when it may not be in their best interests (Kahn, 2009). In order to sustain the system of patriarchy, whether conscious of it or not, men will exclude or sanction unacceptable masculine (health) behaviour (Albury, 2005; Hall, 2004; Phillips, 2005). So-called 'internal hegemony' operates so that men as a group benefit, but with potential 'dire consequences' to individual members (Kahn, 2009; Wetherell & Edley, 1999), such as those suffering MI or in need of MHS.

This study revealed how masculinity is not singular but plural, changing across context and time (Courtenay, 2011). This suggests that men have agency in picking up or rejecting masculinities. Participants cannot be viewed simply as victims of gendered health practices therefore, but as active in 'generating a variety of male roles that variously influence their health'

(Courtenay, 2011, p. 347). While the atypical man might allow for the expression of emotion, the macho man constrains it. The sociologist Giddens (1986) suggests that gender identities arise as a combination of both individual and structural influences, and how men negotiate the relationship 'constitutes men's gender practices' (in Courtenay, 2011, p. 23). By drinking and expressing emotion in the pub, but denying experiencing distress when at work or on the playground, men in this study were translating structural norms into their daily lives. This presented participants with confusing messages around their MH and led to contesting ideological dilemmas and subject positions. This study therefore highlighted some of the micro-level power interactions that structure everyday gendered interactions within health behaviour (Pyke, 1996), revealing how both agency and structure are at work with men's HSB.

Previous focus-group research has also found that whilst all men acknowledged the machismo in their identity, they may also distance themselves from it (Roberston, 2003). Edley (2001) argues that though men may experiment with alternative identity constructions, they tend rather to stay with

those versions of masculinity which they know from experience work. They have discovered that society treats them better if they put a brave face on their hurts and disappointments.

Edley, 2001, p. 194

Sublimating being a 'non-typical' male was something that O'Brien *et al.* (2005) too found within their own focus-group study. Here men reframed depression as 'workplace stress', supporting a more masculine construction of the 'over-tired worker', rather than admitting to a more feminised 'breakdown'.

Within Western cultures, research has frequently found that men avoid constructing themselves as emotional beings (Edley, 2001). This study shows how discourses of male non-emotionality and embracing of hegemonic masculinity results in negative MH consequences. In maintaining patriarchal constructions, men are therefore the victims of their own claim to power (Kimmel, 1995, p.366).

Connection to Clinical Psychology

The finding in this study that accessing MHS is a challenge to masculinity can account for the low rate of uptake by men at primary healthcare level as reported by UK services providers (Clark *et al.*, 2008; Rethink, 2006, Mind, 2009). It is the first study to address IAPT services using a discourse analytic (DA) approach by explicitly questioning participants about their knowledge and understanding of these services. It is also the first DA study to offer support for this attitude to MHS being present amongst working-class men within a local MH context in the South-East of England. This study shows how, through language, these men use their relationship to MH and MHS to construct their masculinities, and suggests how men are in turn subjectified in relation to these concepts (Edley, 2001).

The study suggests that men are complicit in reproducing hegemonic masculinity at the level of their MH, and that this serves as a marker for judging the behaviour of other men (Connell, 1995). Within clinical practice, it seems therefore that responsible policy makers, those who design services, as well as clinicians (including clinical psychologists) are tasked with educating men in the role that they play in furthering detrimental gendered HSBs and stereotypes. For example, men can be tutored (and so challenged) about the ways in which HSB, role identities and indeed psychological traits, are an adoption of a culture's concepts of femininity and masculinity (Pleck *et al.*, 1994), rather than a preordained biological given. Also psycho-education can be used to normalise distress as a typical response to life circumstances. For example, the fact that men are able to express emotion in certain circumstances – in the role of the 'Part-timer' – could be used as a way of challenging non-emotional constructions of masculinity.

Institutions, including healthcare, are also instrumental in maintaining 'unhealthy beliefs and behaviours among men', and these weaken men's attempts to adopt healthier lifestyles (Courtenay, 2000). Within a critical discursive psychology framework, it is the silence and naturalisation around men's health behaviour that allows inequality to continue. Therefore, it is incumbent on service providers, particularly those at primary care level where men are most under-represented, to address the ways in which they are contributing to this deficit and to plan services accordingly.

How can this be done? The findings of this study suggest MHS cannot expect to target men and women with one ubiquitous message, but that services and messages need to be designed specifically for men. Should MHS and media campaigns take the fluid nature of masculinity into account (Courtenay, 2011), targeted locally-based services and health campaigns would respond better to the changing needs of native clients and contexts.

Lessons from successful services targeting men (e.g. Men's Counselling Service Graz, The Samaritans, CALM) tell us that we need to address men in an explicit way. Powerful campaigns, such as that launched by CALM, where messages are 'raw', and address young men in places that they are typically found (bars, pubs, music venues), are more likely to succeed. CPs can lead in pushing for context-specific and relevant drives.

Since community and clinical samples differ substantially, it seems that services are not recognising, nor meeting men's particular needs. This is in part accounted for in that the symptoms of depression/distress for men and women are different (Branney & White, 2010). Whereas for women they are around internal mental states, for men they are reflected in their externalising behaviour (how they act, talk, interact and use alcohol). Current calls to treatment that focus on 'opening up' or admitting to vulnerability were therefore constructed as traditionally feminised by participants and will fail to attract men. If services marginalise externalising behaviours in favour of emotion, they may be missing the signs of MI in men (Branney & White, 2010).

Since SPs are created at the moment of being 'hailed' (Edley, 2001), rather than position men who need services as 'vulnerable', MH campaign messages could, for example, subjectify potential clients as 'active' and 'powerful' in their own recovery. Recent MH think-tank documents (such as *Mind your Head*, 2006), argue that health services should give greater consideration to identifying male-specific distress. The way in which services position male clients therefore, may impact positively on uptake.

There is some indication in this study that male distress is indeed masked and that it does not present in the ways in which MHS might be expecting. Using language that is acceptable to men, such as dealing with feelings couched as 'fighting a battle', might also serve to engage male clients. This concurs with suggestions by Kingerlee (2011), who argues for the use of male-specific metaphors in addressing the nature and treatment of men's MI.

Men's vulnerabilities to MI become more marked under circumstances of social change and unrest (Conrad & White, 2007). This is particularly true of the current global economic climate, where men are faced with financial constraints, the likes of which have already had a negative impact on their MH (WHO, 2011). For example, since the start of the financial crisis in Greece, we have seen a 40% increase in suicide rates, as well as a marked rise in depression and anxiety (Smith, 2011). Given how MI was framed in participants' talk in reference to hegemonic constructs (including providing financially for the family) it is likely that in the absence of economic certainty, men will continue to experience higher levels of MI in the UK in the months to

come. Men are also more likely to be subject to stigma and shame as a result, preventing them from accessing the help they need. At this time it becomes crucial therefore that GPs and MHS need to be equipped to identify vulnerable men, direct appropriate messages, and provide tailored male-specific treatment.

Limitations

The use of naturally occurring dialogue within discursive research might be preferred over somewhat 'artificial' focus-group or interview material. However, for the purposes of this study (and others like it), it was necessary for the researcher to create situations in which men were encouraged to talk about the difficult topics of MI and MHS. While it might be desirable to analyse the way in which men talk naturally, it would have been difficult, particularly given the sensitivity of the topics under discussion. The nature of MI and MHS were threatening to men and are likely to have prevented them from volunteering to take part. The researcher was faced with hesitant participation from men who felt uncomfortable with others whom they did not know. Interviews were therefore deemed appropriate. Future research however might consider ways in which focus-group participation might be made more attractive to young men, perhaps by including more naturally occurring friendship groups.

I would have liked to have the time to follow up some of the discourses that men discussed, particularly those around how stigma and shame were active in curtailing men's HSB. However, given the time constraints on this research,

this was not always possible. Also I was aware that any attempt to further unpick discourses would increase the impact of my own discourses on those of the participants. I was therefore constantly aware of the co-construction of meaning between myself as a female researcher, representing MH care, and the young men I was researching. Furthermore it is possible that being a female researcher, whom male participants might identify as middle-class, may have made the 'feminised' and 'othering' constructions of MHS more salient than they would otherwise have been.

Though the wider male population would arguably have access to the same constructions around MI, MH and MHS, discourses inevitably reflect context, including socio-economic, racial, cultural and sexual orientation factors. A broader insight into the variety of available constructions around masculinity will be achieved if future research selects participants from a greater diversity of men. This would determine how representative those constructions presented here are of wider constructions around mental health.

Using a new method, critical discursive psychology (CDP), to study MI and MHS, this study has provided evidence supporting recent qualitative and quantitative research in the area of men's health. Crucially, using CDP has elicited confirmation for current MH campaigns in thinking strategically about the ways and means in which we consider men's MH needs within the context of their masculinity and the current NHS climate.

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APPENDICES

Appendix A

University Ethics Approval

Dr Adrian Coyle
Chair: Faculty of Arts and Human Sciences Ethics
Committee
University of Surrey

Tina Cohen
Trainee Clinical Psychologist
Department of Psychology
University of Surrey

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21st June 2011

Dear Tina

Reference: 608-PSY-11 RS

Title of Project: Using discourse analysis to explore how young working class British men construct men's mental health services

Thank you for your re-submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given a favourable ethical opinion.

If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.

Yours sincerely



Dr Adrian Coyle
Chair



A history of shaping the future since 1891

Chair's Action

Ref: 608-PSY-11 RS
Name of Student: TINA COHEN
Title of Project: Using discourse analysis to explore how
young working class British men construct
men's mental health services
Supervisor: DR DORA BROWN
Date of submission: 18TH APRIL 2011
Date of re-submission: 21ST JUNE 2011

The above Project has been re-submitted to the FAHS Ethics Committee.

A favourable ethical opinion has now been given.

Signed: 
Dr Adrian Coyle
Chair

Dated: 6th July 2011

Appendix B

Recruitment Poster

MEN!

Can you help with some research?

I'm a trainee clinical psychologist doing research into men and mental health and I'd like to talk to YOU.

My name is Tina Cohen and I'm a trainee clinical psychologist at the University of Surrey in Guildford. As part of my training I'm conducting research into what young men understand about mental health and mental health services and why men are reluctant to approach their doctors about issues such as:

- Feeling anxious, stressed, tense muscles
- Feeling miserable or depressed a lot
- Not sleeping
- Tired all the time
- No interest in things (even your girlfriend!)
- Can't concentrate at work
- Overdoing the booze or drugs

'Stress' affects all of us, but research shows that men find it more difficult to talk about. This means that their mental health can suffer, and they may feel alone, or not 'manly' if they admit they're not coping with things.

I'm interested in talking to young men about this topic for my research. You would take part in a group discussion (a focus group) with about 6 other men of similar backgrounds which would take no more than one hour of your time.

Interested? If you are:

- male
- aged 18-35
- left school at 16,
- earn less than £25,000 a year (or are not working)

... then I would like to hear from you.

You can contact me, Tina Cohen, by email: t.cohen@surrey.ac.uk and I will get in touch with you. (Please leave me your mobile number too). I look forward to hearing from you! If you take part, I will enter you into a draw for a High Street voucher.

Appendix C

Information sheet

Department of Psychology
University of Surrey
Guildford, Surrey GU2 7XH UK

Mrs T.S.Cohen
Trainee Clinical Psychologist

t.cohen@surrey.ac.uk
www.surrey.ac.uk

INFORMATION SHEET

Exploring how young British men talk about men's mental health and mental health services

The study has received a favourable ethical opinion from the Ethics Committee of the Faculty of Arts and Human Sciences at the University of Surrey

My name is Tina Cohen and I am a trainee Clinical Psychologist studying at the University of Surrey in Guildford. As part of my training, I have to undertake a piece of research. I have decided to explore how young men between the ages of 18 and 35 talk about mental health and mental health services. This Information Sheet invites you to take part in this research study.

Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

Part 1 of this sheet tells you the purpose of the study and what you would need to do if you take part.

Part 2 gives you more detailed information about the study will work.

If you decide you would like to take part in my research, I will arrange to meet up with you to go through this Information Sheet and Demographics Sheet with you and answer any questions you may have. This will take about 15 minutes and we can meet somewhere convenient to you (eg. in a Starbucks). You may also contact me if anything is not clear; my e-mail address is at the top of this sheet. Please feel free to talk to other people (friends, family, colleagues) about the study if you wish.

PART 1

What is the study about?

The study is about how young British men think about mental health and mental health services.

What is the purpose of the study?

The purpose of this study is to explore how young British men think about mental health.

Who is carrying out the study?

Myself, Tina Cohen, a Trainee Clinical Psychologist at the University of Surrey. The research will form part of my Doctorate in Clinical Psychology, which is a postgraduate qualification. The study is being conducted under the guidance of the University of Surrey, who is funding the project.

Why have I been invited?

You have been invited to take part because you are a young British man aged 18-35 who is earning less than £25,000 per year.

Do I have to take part?

No. It is up to you to decide whether or not to join the study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen if I take part?

If you decide to take part, you will take part in a focus group with between 5 and 7 other men like yourself. A focus group is where you and these other men sit together in a room with me the researcher and discuss a topic. In this case it is men's mental health. The room will be at the University of Guildford (easy to reach by train or car). The focus group will last about an hour and a half and will take place in a University meeting room. I will cover your travel costs. The focus group will be audio recorded. Later on, should you wish to do so, you will be invited to comment upon the findings, and offered a copy of the final research results.

I will not require you to talk about anything you do not wish to. However, it could be that you choose to talk about some difficult experiences. You will be offered the opportunity to speak to someone for emotional support should you need this afterwards. I can speak to you on an individual basis, or if you would prefer you can speak to my research supervisor, Dora Brown who also works at the University of Surrey. I will also give you the telephone numbers of counselling support groups that you can phone if you need it. This information is available from Tina and from Dora Brown, research supervisor, and is on the Debrief Sheet, which will be given to you after the focus group is complete.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any personal data, including the transcriptions, will be stored in a locked cabinet in my home. Any information, like the transcripts, used in the final research report will be completely anonymised, which means no one will know your name or anything else that could identify you. Direct quotes may be used but only in a form that will not identify you personally, for example, all references to people and places will be anonymised. All personal data will then be kept on a password-protected

memory stick for up to five years after completion of the study, and stored in a locked cupboard in the research supervisor's office.

An exception to maintaining confidentiality may arise if any of the people taking part in the focus group/ interviews reveals anything that I feel may be of concern or a risk, either to themselves or others. This is highly unlikely, but should this happen; I would be obliged to follow University procedures, which may require breaking confidentiality.

If the information in Part 1 has interested you and you are considering taking part in the research, please read the additional information in Part 2 before making any decision.

PART 2

What will happen if I don't want to carry on with the study?

You can decide at any time to pull out of the study and all data collected from you will be destroyed.

Will I be paid?

I will reimburse the cost of you travel to and from the University to take part in the focus group. I will also enter you in a draw for a High Street voucher.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to me and I will do my best to answer any questions. Alternatively, if you wish to speak to someone other than myself, about any aspect of the research, you can also contact my research supervisor Dr Dora Brown at Dora.Brown@surrey.ac.uk.

What will happen to the results?

A copy of the final report will be held in the University of Surrey. It is also my intention to publish a copy of the report in an associated professional journal. I can send you copies of this if you wish.

Who has reviewed the study?

The study has been reviewed by representatives of the University of Surrey.

Thank you for taking time to read this Information Sheet. I will be in touch to advise you of the dates for meeting up with me and for the focus group. If you have any queries or need further information before then please contact me:

Tina Siobhan Cohen
Trainee Clinical Psychologist
University of Surrey
T.Cohen@surrey.ac.uk

Consent Form

Department of Psychology
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Guildford, Surrey GU2 7XH UK

Mrs T Cohen
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Participant Identification Code:

CONSENT FORM

Exploring how young British men talk about men's mental health and mental health services

The study has received a favourable ethical opinion from the Ethics Committee of the Faculty of Arts and Human Sciences at the University of Surrey

Title of Project: Using discourse analysis to explore how young working class British men construct men's mental health and mental health services

Name of Researcher: Tina Cohen, Trainee Clinical Psychologist

Please initial in the boxes below

1. I confirm that I have read and understand the Information Sheet dated March 2011 for the above study. I have had the opportunity to consider the Information and ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I understand that the research data collected during the study may be looked at by other individuals from the research team, sponsor, or regulatory authorities.
4. I understand that the study will involve audio recording my interview with the researcher.
5. I understand that the final report from this study may use direct anonymised quotes from my interview.



6. I understand that in the event that I disclose information which may indicate risk to myself or others, the researcher will be obliged to follow university risk procedures that may require release of my personal data.

☐

7. I consent to my personal data, as outlined in the accompanying information

☐

sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

8. I understand that in the event of my suffering a significant and enduring injury (including illness or disease) as a direct result of my participation in the study, compensation will be paid to me by the University, subject to certain provisions and limitations. The amount of compensation will be appropriate to the nature, severity and persistence of the injury and will, in general terms, be consistent with the amount of damages commonly awarded for similar injury by an English court in cases where the liability has been admitted.

☐

9. I confirm that I have read and understood the above and freely consent to participating in this study. I have given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

☐

10. I agree to take part in the above study.

☐

.....
Name of Participant

.....
Date

.....
Signature

.....
Name of Person
taking consent

.....
Date

.....
Signature

When completed: 1 for participant and 1 for researcher file



Demographics Sheet

Demographic Information Sheet
June 2011

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Participant Identification Code:

DEMOGRAPHIC INFORMATION SHEET

Exploring how young working class British men talk about men's mental health and mental health services

The study has received a favourable ethical opinion from the Ethics Committee of the Faculty of Arts and Human Sciences at the University of Surrey

Please can you answer the following questions:

1. What is your age? _____

2. How would you classify your ethnicity (please tick)?

White	White	Asian	Black	Chinese	Other
British	Irish	British	British	British	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Are you employed? Yes No

If you answered Yes, what job/s do you do? _____



Debrief Sheet

Department of Psychology
University of Surrey
Guildford, Surrey GU2 7XH UK

Mrs T.S.Cohen
Trainee Clinical Psychologist

t.cohen@surrey.ac.uk

Exploring how young working class British men talk about men's mental health and mental health services

The study has received a favourable ethical opinion from the Ethics Committee of the Faculty of Arts and Human Sciences at the University of Surrey

The major information about the research is on the information sheet, which is yours to keep. However, if you have any other questions about the study, please feel free to ask.

You can contact the researcher, Tina Cohen, at T.Cohen@surrey.ac.uk

If you would like to talk more about the research, please contact the research supervisor Dora Brown at Dora.Brown@surrey.ac.uk.

If you feel there are issues raised during the research, you can contact:

1. **Mind info line:** 0300 123 3393 or info@mind.org.uk

Mind can provide information on a range of topics including types of mental distress, where to get help, drug and alternative treatments and advocacy. They can give details of help and support for people in their own area.

2. **The Samaritans:** 08457 909090 or jo@samaritans.org.uk

The Samaritans provide confidential non-judgmental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair.



Appendix D

Semi-structured interview questions

Guide questions for interviews/ focus group

What do you think mental health is?

What do you think mental illness is?

What do you understand by mental health services?

What do you know about IAPT (explain acronym if required)?

Appendix E

List of Acronyms

Acronyms

CALM	Campaign against living miserably
CDP	Critical discursive psychology
DA	Discourse analysis
DoH	Department of Health
DP	Discursive psychology
DSM	Diagnostic and Statistical Manual
GP	General Practitioner
HSB	Help seeking behaviour
IAPT	Improving access to psychological therapies
ID	Ideological Dilemma
IR	Interpretative repertoire
MH	Mental health
MHS	Mental health services
MI	Mental illness
MSP	Male specific profile
MSRI	Male sex role identity
ONS	Office of National Statistics
SC	Social construction/ ism
SP	Subject position

Appendix F

Sample transcript extract

1 Interviewer: what do you understand by mental health?

2

3 Colm: I suppose it's ahh a depression, and finding it hard to cope with certain
4 situations, feeling very down all the time, and quite ill, not wanting to go out,
5 that's kind of what I'd say is mental health, that's it [...] I don't know if it's due to
6 family background or abuse or stuff like that, difficult upbringing, also the
7 nationality as well, adjusting, how we live and our attitudes is quite different
8 [...]

9

10 Interviewer: and do you see a difference between boys and girls?

11

12 Colm: its 50/50 I think, it doesn't seem to be more males or more females,

13

14 Interviewer: so if I ask you what you think mental illness is, what would you
15 say?

16

17 Colm: ummm, illness, umm, I suppose unable to cope with ummm everyday
18 life so waking up in the morning and nothings right for you, feeling down,
19 negative, nothing can go right, ummm depressed, umm I suppose you will
20 have some highs but you have a sense of lethargy

21

22 Interviewer: a lot to do with depression?

23

24 Colm: I think so

25

26 Interviewer: mental health services, what do you know about them?

27

28 Colm: I don't know a lot about mental health services, personally, umm I
29 haven't accessed mental health services, we have where I work we have a
30 free service for staff and their families that we can go to if we have any issues,
31 but umm

32

33 Interviewer: what sorts of services do they offer?

34

35 Colm: anything from feeling depressed, having trouble with money, work
36 related issues, we can call them up and we can see a therapist if we wish and
37 that's all paid for... I have accessed them myself probably 7 or 8 years ago to
38 be honest, I found them a help, just to have someone different to talk to umm
39 and for them to give you some direction really ummm into help you get back
40 on track

41

42 Interviewer: so mental health services support you to get back on track

43

44 Colm: I think so, umm I think the most important thing that mental health
45 services just want to listen to you and to your problems, umm and to give you
46 direction, you know things will get better and to give you ways in which you
47 can support yourself to do that coz, at the end of the day, umm, you know
48 you're the one that's got to put the work in to get better and I suppose mental
49 health services can only support you so much by telling you ways in which

50 you can help yourself, you know, but you're the one who's got to put the work
51 in to get well again really

52
53 Interviewer: what do you know about psychologists?

54
55 Colm: yeah, ummm they're all mad, ummm what do I know about
56 psychologists in what sense? Their work?

57
58 Interviewer: their work?

59
60 Colm: I suppose its ahh looking into a patients problems and umm how to
61 support them in their daily life so also I suppose it might be helping to
62 diagnose them, to you know.... And partly getting them diagnosis, ummm
63 supporting them in their daily lives, their routines, how staff can support
64 them...

65
66 Interviewer: that's a good answer... do you think that if you weren't feeling
67 mentally well you might visit your GP and tell them?

68
69 Colm: I mean personally I would, but I have a lot of friends who I think the say
70 more working class man, they wouldn't say go to a GP, they'd just kind of deal
71 with it you know, I'm a working class man, I don't need help you know,
72 ummm, I dunno just bottle it up, I suppose its more manly to just try and deal
73 with it than go and see someone for help, but personally umm I'd have no
74 problems going to see a GP if I was feeling unable to cope in any way, umm,
75 seeking support for, in ways that could help me, but ummm I'd say a lot of
76 people my age and you know, being male, I don't think they would access it ,
77 they'd be, see themselves as weak if they do access that support from a GP,
78 ummm I definitely see that with my brother for instance, he's a very kind of
79 working class, down to the bone and kind of don't need help from anybody, I
80 can sort it out for myself, umm, I think a lot of his friends are kind of the same,
81 wouldn't access outside support try and deal with it umm in any way they can

82
83 Interviewer: what do you think the link is with working class and not admitting,
84 wanting help?

85
86 Colm: Ummm I think its probably about shame really [...] I think a lot of men
87 would think it's quite shameful to access help from a umm you know doctor or
88 a psychologist, to get help with their mental health, ummm and they you know
89 might be you know I just need to deal with it, I need to sort it out myself, ooh I
90 would accept some help myself, so I think its kind of shameful for a lot of men
91 you know, to be seen, as you know being mentally unstable in any way for
92 whatever whether it be depression or anything else so ahhh I think its
93 probably that kind of statement, I don't think ummm people in kind of middle
94 class they're more, umm, they're ready to take the advice and support, they
95 don't seem to have a big issue about it, you know, that's what I think anyway

96
97 Interviewer: right, and why do you think there would be a differential between
98 working class and middle class people?

99

100 Colm: umm, I don't know really, ummm I think with middle class, ummm that
101 families tend to speak more about their issues really ummm whereas I think in
102 a working class background or something something, that kind of lower
103 working class background, its kind of more umm you know if your parents
104 deal with things and they bottle it up, then you have that same kind of feeling
105 too that I have to deal with it whereas I think middle class or upper class
106 people you know, I think they find it easier to kind of access support and I
107 think attitudes within the family tend to go down the line if that makes sense
108

109 Interviewer: so thinking about your friends coz you said you think they
110 wouldn't find it so easy to access help, what do you think they would think
111 about visiting a psychologist for example?
112

113 Colm: Ummm I think they'd find it quite embarrassing, some of them, I don't
114 think they'd ever tell me, umm that they were seeing a psychologist or that
115 they were accessing some kind of mental health support, you know, I don't
116 think they would tell me, I think they would keep that bottled up, they might
117 break down you know with me, or in front of me, I don't think they would tell
118 me if they were actually seeing a psychologist or any kind of mental health
119 [service]. I think they'd see that as opening up too much and showing their
120 weakness ummm too much I think
121

122 Interviewer: what is it about seeing a psychologist that is about showing
123 weakness?
124

125 Colm: I suppose to others it might seem that you know again that you're just a
126 bit weak and you know you cant do it yourself and I know lots of people's
127 attitudes are just you know, just cheer up a bit, get over it, it cant be that bad,
128 you've got this and that you know things may may seem rosy, you know your
129 perception, you might not feel very good yourself, you get over over it, it cant
130 be that bad. I think that's why people tend to hold it in because they might be,
131 you know you might have a good job, you might have a house, a family so
132 everybody's umm thought of is you've got all that so why, why you unwell,
133 why are you, why do you feel down, what is it that's making you feel down,
134 you've got all this
135

136 Interviewer: so being unwell you cant be unwell if you have a nice a nice
137 house, because being unwell means something about losing your house
138

139 Colm: yeah I think that's it really because people tend to think you know, if
140 you've got everything you need such as a ummm a home, a family or a
141 girlfriend or umm a job that you're umm comfortable with then what else can
142 go wrong? So people don't kind of see out of that box, you know, I take myself
143 for instance you know on the outside it might seem that my life's because you
144 know, I've got a nice job that I really lob, you know, I've got a home, you
145 know, I've got [my girlfriend] , so everything might seem that its great, people
146 don't know a lot about my childhood, you know, I went into foster care you
147 know and dad wasn't around, and my mom had MS so there's all those
148 things that you kind of fight with you know, going through your life, and you
149 know, I've had stages of two or three months where I'm quite down or

150 depressed because you know, I've gone back to thinking you know what if this
151 happened, that happened, what if my mom didn't have MS and I wasn't
152 fostered so yeah people would see that I've kind of got everything round me
153 that I need but they don't really know what's going on outside that and they
154 don't bother to ask a lot of the time

155
156 Interviewer: maybe men don't want to know they don't want to talk about it
157

158 Colm: no, no, I, I [...] and there's only a couple of friends I'd feel comfortable in
159 um telling that I think would actually help me, I think all of my other friends
160 would just sit there and nod and agree and say look its alright, really be, they
161 wouldn't want the conversation, they'd just want it to be over [laughs] and
162 they'd be thinking you've got everything you need so what's the problem
163

164 Interviewer: and where do you think that attitude comes from? That belief?
165

166 Colm: ummm, ummm dunno, I suppose you kind of get that from your
167 parents, I, its your upbringing and umm your parents have to chose the
168 support and love and attention, and kind of its ok to cry, its ok to seek support
169 when you need it whereas a lot of families, more so in working class families
170 umm its not kind of encouraged, just kind of don't tell your problems to
171 anybody, keep them to yourself or within the family, you know, don't tell
172 people about that
173

174 Interviewer: because it's shameful?
175

176 Colm: yeah
177

178 Interviewer: and do you think its different the way boys and brought up and
179 the way girls are brought up?
180

181 Colm: umm yeah I do, I think, I suppose its different for being coz I was
182 brought up well from the age of ten onwards in a family full of girls and women
183 sometimes that nice, other times, definitely girls and women find it easier to
184 discuss their problems and get upset and get things off their chest and I think
185 it seems if you're a boy or an adult male umm it would seems a bit weak if
186 you know you cry or get upset or discuss your problems and I think it is easier
187 umm as a female to talk about your issues
188

189 Interviewer: and do you think it would be easier for a female then to access
190 mental health services because of that?
191

192 Colm: yeah, well obviously mental health services are open to everybody but
193 women access mental health [services] more than males I would say, ummm
194 don't know if that's true? I expect that is [...] I think men as well they might not
195 continue with the therapy as well. They might even halfway through therapy
196 they might say they can deal with it themselves, they say I can deal with it
197 now and try and deal with that themselves, I've definitely come across that
198 with students I deal with whereas I think females are more, umm, they see

199 their support in sessions, something they will fulfill the whole course til they're
200 well.

201
202 Interviewer: so the process is as important as the content to girls. So how
203 come you're able to see yourself differently to your brother?
204

205 Colm: umm, in a lot of ways we're the same but we've been brought up very
206 differently, coz I went into care when I was I think 8 or 9 years old, I see
207 myself as the lucky one actually you know it was me, my brother and my mum
208 who lived together umm and my mom had MS so she was in a wheelchair so
209 my brother kind of had to look after me and my mum and when I was 12 I had
210 lots of issues, not going to school and things like that so he had to be the kind
211 of father figure to me and when I moved into foster care I was the lucky one
212 because I went into a big house with lots of animals, lots of people, was given
213 lots of presents and taken out on trips and things like that, whereas my
214 brother still had to go to work at 16, go home, support my mum, cook the
215 meals, feel guilty when he wanted to go out that he was leaving her, I
216 suppose we've had quite a different upbringing, our attitudes on mental health
217 are very different, my attitude is if you have an issue get support like doctors,
218 psychiatrists, psychologists, my brother's attitude would be I don't need to talk
219 to anybody about that I can deal with it myself you know. He wouldn't talk to
220 me about that if he had, so I suppose he's been supporting people his whole
221 life so ummm he's not been given the ok from his parents to get help for
222 yourself and discuss issues
223

224 Interviewer: He's not had the opportunity to learn that whereas you might
225 have
226

227 Colm: no, he's always been the helper, just get on with it, you have to help
228 rather than be helped
229

230 Interviewer: yeah and do you think it's affected the kind of man that he is?
231

232 Colm: absolutely, he's [...] and a lot of his friends are like it as well, he's umm
233 quite I think he's quite a bitter person now, he's not jealous of me coz it was a
234 difficult time for him to see his brother go off umm to be foster but um there's
235 a part of him I think that he wishes it was him umm though he wouldn't say he
236 has mental health issues, I would say he does have mental health issues,
237 because you know he does have problems sometimes with his anger and you
238 know he doesn't talk about his issues and I think that's sometimes part of you
239 know mental health, not being able to discuss your issues with anybody,
240 bottling all those things up, you know, he struggles with it really.

Research Log

1	Formulating and testing hypotheses and research questions	x
2	Carrying out a structured literature search using information technology and literature search tools	x
3	Critically reviewing relevant literature and evaluating research methods	x
4	Formulating specific research questions	x
5	Writing brief research proposals	x
6	Writing detailed research proposals/protocols	x
7	Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly	x
8	Obtaining approval from a research ethics committee	x
9	Obtaining appropriate supervision for research	x
10	Obtaining appropriate collaboration for research	x
11	Collecting data from research participants	x
12	Choosing appropriate design for research questions	x
13	Writing patient information and consent forms	x
14	Devising and administering questionnaires	x
15	Negotiating access to study participants in applied NHS settings	x
16	Setting up a data file	x
17	Conducting statistical data analysis using SPSS	x
18	Choosing appropriate statistical analyses	x
19	Preparing quantitative data for analysis	x
20	Choosing appropriate quantitative data analysis	x
21	Summarising results in figures and tables	x
22	Conducting semi-structured interviews	x
23	Transcribing and analysing interview data using qualitative methods	x
24	Choosing appropriate qualitative analyses	x
25	Interpreting results from quantitative and qualitative data analysis	x
26	Presenting research findings in a variety of contexts	x
27	Producing a written report on a research project	x
28	Defending own research decisions and analyses	x
29	Submitting research reports for publication in peer-reviewed journals or edited book	
30	Applying research findings to clinical practice	x